EF 10.1

PATIENT INFORMATION

Name _____ DOB _____ SS# _____

Address _____ Driver's License # _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Name of Parent or Spouse _____

Have we examined other members of your family? ☐ Yes ☐ No

If yes, whom? _____

EMPLOYMENT

Occupation _____ Employer _____

School _____

Do you use a computer? ☐ No ☐ Yes: How many hours per day? _____

METHOD of PAYMENT

☐ Cash	☐ Medicare	☐ Vision Insurance	☐ Credit Card
☐ Check	☐ Medicaid	☐ Medical Insurance	☐ Worker's Compensation

MEDICAL / VISION INSURANCE

Medical Insurance Company _____

Vision Insurance Company _____

Medicare Supplemental Insurance _____

Name & Address of Family Physician

_____

_____

_____

_____

Name & Address of Previous Eye Doctor

_____

_____

_____

_____

HOW DID YOU FIND OUT ABOUT OUR OFFICE

☐ Yellow Pages	☐ Location	☐ Radio	☐ Family Doctor
☐ Newspaper	☐ Mailouts	☐ Television	☐ Insurance Company

Referred By: (name) _____