

DATE _____

PATIENT'S MR NAME: MS _____ AGE _____ DATE OF BIRTH ____/____/____ SS# _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE: () _____ E-MAIL ADDRESS: _____

OCCUPATION: _____ EMPLOYER: _____ WORK PHONE: () _____

NAME OF SPOUSE, PARENT, OR GUARDIAN (if applicable) _____ PHONE: () _____

NAME OF CHILDREN (if applicable) _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____ PHONE: () _____

WHOM MAY WE CONTACT IN THE CASE OF AN EMERGENCY? _____ PHONE: () _____

APPROXIMATE DATE OF LAST EYE EXAMINATION: _____ BY DOCTOR _____

WHAT IS THE MAIN REASON OR PROBLEM THAT HAS CAUSED YOU TO COME IN TO SEE US TODAY? _____

DO YOU HAVE VISION INSURANCE? ___ YES ___ NO

VISION INSURANCE PLAN:

- EYEMED
- BLUE VIEW
- DAVIS
- TRICARE STD Active Retired
- TRICARE PRIME Active Retired
- BLUE VISION
- VSP
- OTHER _____

INSURED ID #: _____

INSURED NAME: _____

INSURED EMPLOYER: _____

DO YOU HAVE MEDICAL INSURANCE? ___ YES ___ NO

MAJOR MEDICAL INSURANCE PLAN:

- ANTHEM BCBS
- AETNA
- CIGNA
- MEDICARE
- UNITED HEALTH CARE
- SENTARA / OPTIMA
- TRICARE STD Active Retired
- TRICARE PRIME Active Retired
- OTHER _____

INSURED ID # _____

DATE OF BIRTH _____

MEMBER ID # _____

PREFERRED METHOD OF PAYMENT: ___ CASH ___ CHECK ___ DEBIT ___ VISA ___ MASTERCARD ___ DISCOVER