

WELCOME TO OUR PRACTICE

(Dr./Mr./Mrs./Ms./Miss) _____ Date _____

Name _____

Date of Birth _____ Age _____ Last Four of SSN _____

Address _____

City/State/Zip _____ Spouse _____

Phone(H) _____ Cell _____ Work _____

Occupation _____ Employer _____

Name of Parent or Guardian _____

Email Address _____

Referred by _____

INSURANCE INFORMATION

Many health issues related to the eyes are covered by insurance. Please indicate your health insurance and vision insurance. If you have an eye condition your health insurance may be billed.

Medicare _____ Blue Cross/Blue Shield _____ United Health Care _____ Aetna _____

Vision Service Plan _____ Vision Care _____ Eyemed _____ Davis Vision _____

Avesis _____ Always Care _____ Other _____

Tri Care for Life/Standard/Prime (we need your policy number) _____