

ARMESTO EYE PATIENT INFORMATION

NAME _____ SOCIAL SECURITY # _____

ADDRESS _____
STREET CITY STATE ZIP

DATE OF BIRTH ____/____/____ AGE _____ M / F _____ OCCUPATION _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____ MARITAL STATUS _M_ _S

EMPLOYER _____ ADDRESS _____

SPOUSE NAME _____ SPOUSE'S EMPLOYER _____

EMAIL ADDRESS _____

EMERGENCY CONTACT _____ RELATIONSHIP _____ PHONE _____

PLEASE COMPLETE IF UNDER AGE 18 OR A STUDENT:

PARENT/LEGAL GUARDIAN NAME _____ PHONE _____

ADDRESS _____

HOW DID YOU HEAR ABOUT US? [] FRIEND / RELATIVE Name: _____
[] NEWSPAPER [] YELLOW PAGES [] RADIO _____
WHO MAY WE THANK? STATION

[] REFERRED BY DR. _____

FAMILY DOCTOR _____ PHONE # _____

IF WORKERS' COMP _____
NAME ADDRESS

INSURANCE INFORMATION: PLEASE NOTE WE MUST HAVE SSN AND DATE OF BIRTH TO SUBMIT CLAIM

PRIMARY **MEDICAL** INSURANCE _____ ID# _____

NAME OF SUBSCRIBER _____ DATE OF BIRTH _____

RELATIONSHIP TO SUBSCRIBER _____ SUBSCRIBER SS# _____

SECONDARY INS. _____ ID# _____

SUBSCRIBER SS# _____ SUBSCRIBER'S DATE OF BIRTH _____

VISION PLAN: YES NO PLEASE NOTE WE MAY NOT PARTICIPATE WITH YOUR VISION PLAN.

NAME OF INSURED _____ INSURED'S DATE OF BIRTH _____

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize *Armesto Eye Associates* to furnish information to my INSURANCE CARRIER, EMPLOYER, REFFERRING PHYSICIAN, or OTHER PHYSICIANS concerning my treatment and/or illness.

SIGNED (patient or parent if minor) _____ Date _____