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_____ DOB_____

ADDRESS_____

HOW DID YOU HEAR ABOUT US? [ ] FRIEND / RELATIVE Name: _____
WHO MAY WE THANK?

[ ] WEBSITE/INTERNET [ ] NEWSPAPER [ ] YELLOW PAGES [ ] RADIO _____
STATION

[ ] REFERRED BY DR. _____

FAMILY DOCTOR_____

PREFERRED PHARMACY _____
NAME AND PHONE NUMBER OR ADDRESS

IF WORKERS' COMP_____
NAME OF COMPANY/CARRIER ADDRESS

INSURANCE INFORMATION: Although we may have copied your card, please fill in the subscribers name and date of birth. We cannot submit the claim without the date of birth of the subscriber.

PRIMARY **MEDICAL** INSURANCE_____ ID#_____

NAME OF SUBSCRIBER_____ DATE OF BIRTH OF SUBSCRIBER_____

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 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_____