



NEW PATIENT INFORMATION
Please print clearly and fill out completely

Name (First, MI, Last): _____

Date of birth: _____ Age: _____ Sex: Male/Female Marital status: M / S / W / D

Address: _____

City: _____ State: _____ Zip code: _____ Home phone: _____

Cell number: _____ Work number: _____ Email: _____

Social security #: _____ Driver's license #: _____

Employer or school attending: _____ Occupation: _____

Address: _____

How did you learn about us?: _____

Primary care physician: _____ Phone #: _____

Emergency Contact: _____ Phone #: _____

Responsible party/payment information

Parent, spouse or legal guardian: _____ Relationship: _____

Address: _____ Phone #: _____

Primary Insurance: _____ Member name: _____

Social security #: _____ Date of birth: _____ Relationship: _____

Secondary Insurance: _____ Member name: _____

Social security #: _____ Date of birth: _____ Relationship: _____

Available services (please indicate any that may interest you)

- | | |
|---|-------------------------------------|
| _____ Laser vision correction (lasik) | _____ Glaucoma management |
| _____ Corneal surgery and transplantation | _____ Management of dry eye |
| _____ Cataract surgery, including specialty IOLs | _____ Diabetic eye exams |
| _____ Management of corneal infections | _____ Contact lens related problems |
| _____ Routine eye exams for patients age 6 and up | |