



## Patient Information

Last Name	First Name	Today's Date
Address		Date of Birth
City	State	Zip Code
Home #	Work #	Other #
Social Security #		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Employer	Occupation	
Emergency Contact	Phone #	
Relationship to You:		
How Did You Hear About Our Office?		
Your Family Doctor	Phone #	
Your Optometrist	Phone #	
mail Address		

## Insurance Information

Primary Insurance	Secondary Insurance
Insurance Name	Insurance Name
Subscriber's Name	Subscriber's Name
Subscriber's Date of Birth	Subscriber's Date of Birth
Contract #	Contract #
Group #	Group #

I authorize the release of any information necessary, including my medical record,  
to process any insurance claim.

\_\_\_\_\_

**Patient Signature** (or person authorized to sign)

\_\_\_\_\_

**Date**