PATIENT INFORMATION

OFFICE USE:_____

DATE_____EMAIL _____

FIRST NAME_____LAST NAME_____M.I._____

ADDRESS_____

CITY_____STATE_____ZIP_____GENDER (M/F)_____

HOME PHONE_____CELL _____WORK PHONE_____

DATE OF BIRTH_____AGE_____SOCIAL SEC #_____

FAMILY PHYSICIAN_____OPTOMETRIST_____

CHECK ONE: ☐MARRIED ☐SINGLE ☐OTHER PREFERRED PHARMACY_____

CHECK ONE: ☐CAUCASIAN ☐AFRICAN AMERICAN ☐HISPANIC ☐ASIAN

PREFERRED LANGUAGE: ☐ ENGLISH ☐SPANISH ☐OTHER_____

NAME OF SPOUSE_____SPOUSE DATE OF BIRTH_____

IN CASE OF EMERGENCY

ALTERNATE PERSON NOT LIVING WITH YOU_____PHONE_____

INSURANCE/ EMPLOYER INFORMATION

DO YOU HAVE HEALTH INSURANCE? ☐YES ☐NO

DO YOU HAVE VISION INSURANCE? ☐YES ☐NO IN WHOSE NAME_____

IS YOUR HEALTH INSURANCE THROUGH YOUR CURRENT/PAST EMPLOYER? ☐YES ☐NO

NAME OF THAT EMPLOYER_____

PRIMARY INSURANCE

NAME_____

POLICY #_____

GROUP NAME/#_____

SUBSCRIBER NAME_____

SUBSCRIBER SOCIAL SEC #_____

SUBSCRIBER DATE OF BIRTH_____

INS. ADDRESS_____

SECONDARY INSURANCE

NAME_____

POLICY #_____

GROUP NAME/#_____

SUBSCRIBER NAME_____

SUBSCRIBER SOCIAL SEC #_____

SUBSCRIBER DATE OF BIRTH_____

INS. ADDRESS_____

RESPONSIBLE PERSON/ P.O.A. INFORMATION

TO BE FILLED OUT IF PATIENT IS A MINOR, UNDER GUARDIANSHIP, HAS A CUSTODIAN, OR IS NOT FINANCIALLY RESPONSIBLE.

RESPONSIBLE PARTY

FIRST NAME_____**LAST NAME**_____**M.I.**_____

ADDRESS_____

CITY_____**STATE**_____**ZIP**_____**GENDER (M/F)**_____

HOME PHONE_____**WORK PHONE**_____

CELL PHONE_____**DATE OF BIRTH**_____

SOCIAL SEC.#_____

CHECK ONE: ☐**EMPLOYED** ☐**FULL-TIME STUDENT** ☐**PART –TIME STUDENT** ☐**OTHER**

CHECK ONE: ☐**MARRIED** ☐**SINGLE** ☐**OTHER**

EMPLOYER_____

RELEASE TO TREAT MINOR

AS RESPONSIBLE PERSON FOR_____**, I HEREBY GRANT AUTHORIZATION TO TUSCARAWAS EYE CENTRE, INC. FOR MEDICAL TREATMENT AS MAY BE DEEMED NECESSARY FOR HIS/HER EYE CARE.**

SIGNED_____**DATE**_____

RELATIONSHIP_____