EyeCare Associates Optometric Group

General Information

Name: (Last) _____ (First) _____ (MI) _____

Circle One: Mr. Mrs. Ms. Miss. Dr. Other: _____ Nickname: _____

Address: _____ Apt/ Space #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____ Cell: (____) _____ Work: (____) _____

Sex: ☐ Male ☐ Female Birthdate: _____/_____/_____ SS #: _____-_____-_____

Email: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow(er)

Employment Status: ☐ Employed Full Time ☐ Part Time ☐ Student ☐ Not Employed ☐ Retired

Employer: _____ Occupation: _____

Emergency Contact**:** _____ Relation: _____Phone Number: (____) _____

How were you referred to us? ☐ Referred by: _____

☐ Walked By ☐ Yelp ☐ Google ☐ CareCredit ☐ Insurance Company ☐ Website ☐ Facebook

Are you interested in: ☐ Contact Lenses ☐ Glasses ☐ LASIK ☐ Colored Contacts ☐ Sunglasses ☐ Cataracts

Insurance Information

If the patient is a minor please include Parent/Guardians Information Below

Insured Member's Name: _____ **DOB:** _____/_____/_____ **SS#**: _____-_____-_____

Address: _____ Employer: _____ Relation to Patient: _____

Vision Insurance: ☐ VSP ☐ Medical Eye Services ☐ Eyemed ☐ MetLife ☐ Superior Vision

Medical Insurance: ☐ Blue Cross/Shield ☐ Aetna ☐ Cigna ☐ Kaiser ☐ Medicare ☐ Other: _____

ID #: _____ Supplemental Insurance: _____

Please present any insurance cards and photo identification to the receptionist

Photo Identification	Insurance ID Card

Today's Date: _____/_____/_____