



## Patient Information Sheet

Welcome to our office. Please complete all forms and return to the receptionist, who will use this information to prepare your chart. Thank you.

Date: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ City, State & Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Sex: (circle one) male or female (circle one) single, married, widowed, separated or divorced

Social Security#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Are you retired? (circle one) yes or no Date Retired: \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

Whom to notify in case of an emergency? \_\_\_\_\_

Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

### Spouse Information

Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Retired? (circle one) yes or no Date Retired: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Work Address: \_\_\_\_\_

### Patients Under 18 Years of Age

Name of Father: \_\_\_\_\_ Employer: \_\_\_\_\_

Work Address & Phone: \_\_\_\_\_

Name of Mother: \_\_\_\_\_ Employer: \_\_\_\_\_

Work Address & Phone: \_\_\_\_\_

### Insurance Information

**Medical Doctor:** \_\_\_\_\_ Office Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**Primary Insurance:** \_\_\_\_\_ Address: \_\_\_\_\_

Policy#: \_\_\_\_\_ Group#: \_\_\_\_\_ Policy Holder's Name: \_\_\_\_\_

Policy Holder's DOB: \_\_\_\_\_ Policy Holder's SS#: \_\_\_\_\_

Is this an HMO? (circle one) yes or no Do you need a referral/precert to be seen? (circle one) yes or no

**Secondary Insurance:** \_\_\_\_\_ Address: \_\_\_\_\_

Policy#: \_\_\_\_\_ Group#: \_\_\_\_\_ Policy Holder's Name: \_\_\_\_\_

Policy Holder's DOB: \_\_\_\_\_ Policy Holder's SS#: \_\_\_\_\_

Is this an HMO? (circle one) yes or no Do you need a referral/precert to be seen? (circle one) yes or no

Vision Plan Name: \_\_\_\_\_ Policy#: \_\_\_\_\_ Group#: \_\_\_\_\_