WELCOME TO

1. ABOUT YOU

Today's Date:_____/______/________

Patient Name:_______________________________________
LAST FIRST MI

Preferred Name:________________________ ☐Male ☐Female
Title: ☐Mr. ☐Mrs. ☐Ms. ☐Miss ☐Dr. ☐Rev. ☐Other:__________
Birthdate:____/_____/______ Age:______SS#_____-____-______
Mailing Address:_______________________________________
City:_________________________State:_______Zip:__________
Home Phone #: (______)_______-_________________________
Work Phone #: (______)_______-____________ Ext:__________
Cell Phone #:(______)_______-__________________________
E-mail Address:____
Best time/# to reach you:__________________________________
Status: ☐Minor ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed
Spouse's Name:____
Do you have any children? ☐Yes ☐No If yes, how many?_______

Employer:__________________________How long?__________
Employer's Address:_____________________________________
City:_________________________State:_______Zip:__________
Occupation:____

2. INSURANCE INFO

Primary *VISION* Insurance
Co. Name:____
Phone #: (______)_______-__________________________
Insured's ID#:____
Group # (Plan, Local, or Policy #):_____________________
Insured's Name:____
Relation:__________________Birthdate:____/_____/_____
Insured's Employer:_____________________________________

☐ Check if you have *Secondary* Vision Insurance

Primary *MEDICAL* Insurance
Co. Name:____
Insured's ID#:____
Group # (Plan, Local, or Policy #):_____________________
Insured's Name:____
Relation:_________________Birthdate:____/_____/______
Insured's Employer:_____________________________________

☐ Check if you have *Secondary* Health Insurance

3. ACCOUNT INFO

Person ultimately responsible for account
☐ Check if same as above
Name:____
Relation:____
Billing Address:____
City:________________________State:______Zip:____________
SS#:____
Driver's License #:___________________________State:_______
Home Phone #: (______)_______-_________________________
Work Phone #: (______)_______-____________ Ext:__________
Preferred payment method for any balance not covered by my insurance company.: ☐ Cash ☐ Check ☐ Visa ☐ Mastercard
Card #__________________________________ Exp.____/_____

4. IN CASE OF EMERGENCY

Whom should we contact?_________________________
Relation:____
Home Phone #: (______)_______-_____________________
Work Phone #: (______)_______-___________ Ext:______
Cell Phone #:(______)_______-_______________________

Name of Primary Care Doctor:_____________________
Primary Care Doctor's Office:_______________________
Primary Care Doctor's Phone #: (______)_______-_______

5. MARKETING INFO

How did you learn about Spring Hill Eyecare, PLLC/Whom may we thank for referring you? (Please check all that apply)

☐ Friend (name):_______________________________ ☐ Phone Book (which book):___________________________
☐ Family Member (name/relation)__________________ ☐ Drive-by/Sign:________________________________
☐ Internet search (which search engine)____________ ☐ Newspaper ad (which paper):________________________
☐ Insurance directory/website:____________________ ☐ Other:______________________________________

6. CONSENT

By signing this form, I consent to treatment for myself. I give permission for the doctor(s) to examine, diagnose and initiate treatment as deemed appropriate.
Patient's Signature:____Date:___/___/_____