## Patient Information

**Date:**__________

Name_________________________________MI_____DOB___________Male____ Female___

Address_______________________________________________________________

City______________________ State______ Zip_________ SSN#_________________

Home Ph: ___________________Cell Ph:__________________ Email:___________________

Marital Status:___________ Employer:__________________________ ☐ Full Time ☐ Part Time
If You Are A Student, Do You Attend: ☐ Full Time ☐ Part Time ☐ N/A
Is Your Visit a Result of a Workers Compensation Claim? ☐ Yes ☐ No

Primary Care Provider:_______________________ Practice Location:____________________

Emergency Contact Name, Relationship, & Phone #: ____________________________________

## Responsible Party

Name of Person Responsible for Account___________________ Relationship to Patient__________

Address____________________________________________Home Phone________________

Birthdate________________SSN____________________Employer______________________

## Insurance Information

**Vision** Insurance #1________________________Policy ID#______________________________

Group#__________________________Phone Number___________________________________

Name of Insured___________________________Relationship to Patient_______________________

Address__________________________________SSN________________Birthdate___________

**Medical** Insurance #1______________________Policy ID#________________________________

Group#__________________________Phone Number___________________________________

Name of Insured___________________________Relationship to Patient_______________________

Address_______________________________SSN__________________Birthdate___________