# WELCOME TO EYE PHYSICIANS & SURGEONS

DATE_____ BIRTHDATE_____ AGE_____

PATIENT NAME _____
Last First Middle Initial

❑ MALE ❑ FEMALE ❑ MARRIED ❑ SINGLE ❑ WIDOWED

ADDRESS _____
Street City State Zip

PHONE: HOME_____ WORK_____ CELL_____

FOR BILLING PURPOSES, DO YOU WANT YOUR ACCOUNT SET UP IN:
❑ Your Own Name ❑ Joint Account With Spouse ❑ Parent's Account Family Billing

EMPLOYER_____

EMERGENCY CONTACT _____

RELATIONSHIP TO PATIENT_____ PHONE_____

**PRIMARY INSURANCE**

NAME _____

POLICY #_____ GROUP # _____

POLICY HOLDER NAME_____ BIRTHDATE_____

ADDRESS IF DIFFERENT FROM PATIENT_____

**SECONDARY INSURANCE**

NAME _____

POLICY #_____ GROUP # _____

POLICY HOLDER NAME_____ BIRTHDATE_____

ADDRESS IF DIFFERENT FROM PATIENT_____

**TERTIARY INSURANCE**

NAME _____

POLICY #_____ GROUP # _____

POLICY HOLDER NAME_____ BIRTHDATE_____

ADDRESS IF DIFFERENT FROM PATIENT_____

PLEASE SHOW ALL INSURANCE CARDS TO RECEPTIONIST FOR US TO COPY
**IT IS THE PATIENT'S RESPONSIBILITY TO PROVIDE UPDATES OR CHANGES TO THIS INFORMATION**