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: _____/_____/_____