WELCOME TO ADVANCED FAMILY EYE CARE

***Today's date**: ____/_____/_____*

Patient Name: _____

Address: _____ Home phone:_____

City_____ _____State_____ Zip_____ Work Phone:_____ ___

Occupation:_____ Cell Phone:_____

Social Security #: __ _____/_____/_____ Email: _____

Date of Birth:_____/_____/_____

Emergency contact:
If patient is a minor:
Responsible party name:_____
Name:_____

Relationship: _____
Phone:_____

INSURANCE INFORMATION

Primary MEDICAL insurance carrier name:_____

Policy holder's name:_____Date of birth:_____

Policy holder's social security number:_____

Secondary medical insurance if applicable:_____

VISION ***insurance carrier name:_____***

Policy holder's name:_____Date of birth:_____

Policy holder's social security number:_____

MEDICAL HISTORY

Physician:_____ Town_____

Name of Pharmacy_____ Town_____

Date of last eye exam if not done here_____

List all major surgeries, injuries and/or hospitalizations you have had_____

_____