MEMORIAL EYE INSTITUTE

Today's Date _____

Name _____ Birthday _____
First MI Last

Social Security # _____ Age: _____ Gender: M F Race: _____

Address _____

City _____ State _____ Zip _____

☐ Home phone _____ ☐ Cell _____ Please check preferred phone number

email _____ ☐ OK to communicate via email

Employer _____ Business phone _____

Spouse _____ Phone _____

Primary Physician _____ Referring Physician _____

How did you hear about us? _____

Reason for visit today?(circle one) routine exam, problem, explain _____

Prior eye doctor? _____ Date of last eye exam? _____

Do you wear: glasses _____ contacts _____

Medical Insurance

Primary Insurance _____ ID # _____ Group # _____

Policyholder's name _____ Birthdate: _____ SS#: _____

Patient's relationship to policyholder: (circle one) self spouse child

Secondary Insurance _____ ID # _____ Group # _____

Policyholder's name _____ Birthdate: _____ SS#: _____

Patient's relationship to policyholder: (circle one) self spouse child

Vision Insurance

Vision Insurance _____ ID # _____ Group # _____

Policyholder's name _____ Birthdate: _____ SS#: _____

Patient's relationship to policyholder: (circle one) self spouse child

To what MEDICINES or EYEDROPS are you ALLERGIC? ( ) Penicillin ( ) Sulfa ( ) Steroids ( )Aspirin

Other-List _____

Emergency contact: _____ Relationship _____ Phone: _____

If Child, legal guardian: _____ Employer _____ Phone: _____

Is a P.O.A. in place? If yes, name & address _____

X _____ _____
Signature of Patient Date Signature of Responsible Party Date