Patient Information Form

Are you interested in more information for an affordable way to reduce your need for glasses and contacts? YES NO

Are you interested in obtaining a more youthful appearance? YES NO

PLEASE PRINT AND COMPLETE ALL ENTRIES

Patient Name: Last First MI | Date of Birth __/__/__ | Age Sex | Social Security No.

Address: Street City State Zip Code

Home Phone #: (___) ____ - _____ | Cell Phone #: (___) ____ - _____ | Employer Phone #: (___) ____ - _____

Employer name and complete address:

Primary Care Doctor's Name And Address: | Primary Care Doctor Phone #: (___) ____ - _____

Spouse's Name: Last First | Date Of Birth __/__/__ | Social Security No.

Spouse's employer's name and complete address: | Spouse's Work Phone (___) ___-____

Emergency contact full name: | Relationship to you: | Emergency Phone Number (___) ___- ____

Who is financially responsible for this bill? | How will the bill be paid today?

How did you hear of us?

INSURANCE INFORMATION

Primary insurance name and complete address: | Phone of insurance carrier: (___) ___-____

Name of insured: | Insured's D.O.B.: | Relationship | ID Number | Social Security No.

Insured's employer name and complete address: | Employers phone: (___) ___- ____

Secondary insurance name and complete address: | Phone of insurance carrier: (___) ___ - ____

Name of insured: | Insured's D.O.B. | Relationship | ID Number | Social Security No.

This form has been verified for completion by: __________ Date: _________