OHIO EYE ASSOCIATES
EYE SURGERY & LASER CENTER

OHIO EYE OPTOMETRICS

Patient Information

Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Name _____ Home phone#_____

Address _____ Cell phone# _____

City _____ Work Phone# _____

State _____ Zip Code _____

Date of birth _____/_____/_____ Soc. Sec.# _____

Sex ☐ Male ☐ Female Email address _____

Race _____ Preferred Language _____

Employment Information

☐ Employed ☐ Retired ☐ Unemployed ☐ Self employed

Employer _____ Phone # _____

Retired from (company name) _____

Emergency Contact Information

Person to notify in case of emergency Name _____

Relationship _____ Phone# _____

Insurance Information

Please present your insurance cards to be copied.

Primary _____ Group#_____ ID# _____

Secondary _____ Group# _____ ID# _____

Other _____ Group# _____ ID# _____

In whose name is your insurance carried? _____

His/Her date of birth _____/_____/_____ His/Her Soc. Sec.#_____

Who may we thank for referring you to our practice?

☐ Yellow pages ☐ Newspaper ad ☐ Radio ad ☐ Billboard ☐ Other _____

Health care providers

Referring doctor _____ Phone# _____

Optometrist _____ Phone# _____

Primary Care Physician _____ Phone# _____

_____

Patient signature or Authorized party **Date**