WELCOME TO EYE ASSOCIATES NORTHWEST, PC

Date _____

Patient's Name _____ ❒ Male ❒ Female
Last First Middle

Address _____ Home Phone ( )

City _____ State _____ Zip _____ Work Phone ( )

Social Security Number _____ Date of Birth ____ /____ /____

Employer _____ Occupation _____

Marital Status _____ E-mail Address _____

Emergency Contact (not at same address) _____ Relationship _____

Home Phone _____ Work Phone _____

WHO REFERRED YOU TO THIS OFFICE? _____

PRIMARY CARE PHYSICIAN _____ **Phone Number** ( )

ACCOUNT GUARANTOR, IF NOT PATIENT

Patient's relationship to person responsible for bill _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Employer _____ Occupation _____

Employer Address _____

INSURANCE INFORMATION

Primary Medical Insurance _____

Policy Holder/Subscriber _____ Date of Birth _____/_____/_____

Relationship to Patient _____ Employer _____

Policy/Subscriber Number _____ Group number _____

Secondary Insurance _____

Policy Holder/Subscriber _____ Date of Birth_____/_____/_____

Policy/Subscriber Number _____ Group number _____

Other Insurance Coverage for Routine Vision Care Only? ❒ Yes ❒ No

Vision Insurance Carrier _____

Phone Number _____

Policy Holder/Subscriber _____ Date of Birth_____/_____/_____

Employer _____ Relationship to Patient _____

INJURY INFORMATION

Is your visit today injury related? ❒ Yes ❒ No Date of Injury_____/_____/_____

Place of Injury: ❒ Home ❒ School ❒ Work ❒ Auto Accident ❒ Other

Nature or Cause of Injury _____

If work related, name of employer at time of injury: _____

Third party insurer: _____ Claim# _____