Atlantic Eye
CONSULTANTS

WELCOME TO OUR PRACTICE

Date _____

Patient Name (Last, First, MI) _____ SSN _____

Prefer to be called _____ Spouse's Name _____

Address _____

City _____ State _____ Zip _____

Phone (H) _____ (W) _____ (C) _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Email _____

Employment Status: ☐ Active ☐ Retired Occupation _____

Employer _____ Phone _____

How would you like to receive appointment reminders? ☐ Home Phone (Best Time) _____
☐ Work Phone (Best Time) _____ ☐ Cell Phone (Best Time) _____ ☐ Postcard ☐ Email ☐ All Listed

FINANCIALLY RESPONSIBLE PARTY

Patient is responsible for payment of all fees and services rendered unless under the age of 18 or a Power of Attorney (POW) has been appointed.

Person responsible for payment or fees _____ Relationship to Patient _____

Address _____

Date of Birth _____ SSN _____

Employer _____ Phone _____

MEDICAL INSURANCE INFORMATION

Primary Insurance Company _____ Effective Date _____

Policy / ID # _____ Policy Holder's Name _____

Policy Holder's Date of Birth _____ Policy Holder's SSN _____

Policy Holder's Employer _____ Phone _____

Secondary Insurance Company _____ Effective Date _____

Policy / ID # _____ Policy Holder's Name _____

Policy Holder's Date of Birth _____ Policy Holder's SSN _____

Policy Holder's Employer _____ Phone _____

Date of injury (if applicable) _____ *Work related?* ☐ *Yes* ☐ *No*

EMERGENCY CONTACT INFORMATION

Name of nearest family member not living with you _____

Relationship to Patient _____ Phone _____

Address _____

City _____ State _____ Zip _____

HOW DID YOU HEAR ABOUT OUR PRACTICE?

Physician _____ Practice Name _____

☐ Family Member ☐ Friend _____ Family Relation to Patient _____

☐ Online ☐ Yellow Pages ☐ Newspaper ☐ Other _____