Patient Information

Name:____
LAST FIRST MIDDLE Mr. Ms. Mrs. Miss Dr. (Circle One)

Mailing Address:____

City:___________________ State:______ Zip:___________

Home Phone:__________ Cell Phone: __________Email Address:_______________________

**** When you provide us with a wireless telephone number or land line number you are giving us your prior express consent to call that number.**

Date of Birth: _________Age: _______Social Security #:___________________

Sex: M F (Circle One) Marital Status: Married Single Divorced Widowed (Circle One)

Employer:________________________ Work Phone:___________________

Primary Insurance:_________________ Secondary Insurance:________________

SPOUSE OR PARENT INFORMATION

Name:____
LAST FIRST MIDDLE Mr. Ms. Mrs. Miss Dr. (Circle One)

Date of Birth:______________ Social Security #:________________ (only if patient is covered by spouse's insurance)

Spouse OR Parent's Employer:_______________________________

Spouse Work Phone:_________________

PREFERRED PHARMACY for Prescriptions:

Name: _________________________________Location: ____

Phone Number: _________________________

EMERGENCY CONTACT INFORMATION (other than spouse or parent)

Name:___________________________ Relationship:________________

Home Phone:________________ Work Phone:________________

Whom may we thank for referring you to Temas Eye Center?___________________

Who is your Medical Doctor?___________________________________

Who performed your last eye exam?_______________________________

Authorization and Assignment: I hereby authorize my insurance carrier (s) to pay any benefits directly to Temas Eye Center. I authorize Temas Eye Center to release all information necessary, in the course of my treatment, to process insurance claims. I understand and agree that I am responsible for any non-covered charges and services.

Patient's Signature: ___________________________________Date:________________

Parent/Guardian's Signature:______________________________Date:_______________