Citywide Eye Care (complete all questions)

Demographics	
First Name	Last Name
Date of Birth	Gender
Full Address	City: State: Zip Code:
Home Phone:	Cell Phone: Email:
Preferred communication:	Email Phone#
If patient is a Child	
School:	Grade:
Legal guardian name	
Pediatrician's name	Name Phone #

If patient is an Adult	
PCP name and phone #	Name Phone #
Employer	Occupation: Work phone#
Insurance	
Primary Medical Insurance Name / Plan	
Insurance Policy ID	Insurance policy group
Is this a HMO and requires a referral?	HMO? Yes/No Referral needed? Yes/No
What is your co-pay for specialty visit?	Co-Pay amount? $_____
Do you have a deductible?	Deductible amount $ _____ Have you reached your deductible? Yes/No
Social Security #	
Vision Insurance Name/Plan	Name: Vision Insurance ID #
	If patient is not the primary holder on the insurance plan
Primary full name	
Address	
Gender	Date of birth
Social Security # of Primary	Phone #
Employer	
Relationship to Insure	
Vision Plan Insurance Name	Insurance ID
How did you hear about us?	Who should we thank for your referral?
Would you like to be a part of our patient portal?	Yes/No Must provide email: