

Welcome to Classic Vision Care

Patient Information

Thank you for choosing our practice for your eye care needs. If you have any questions or concerns about information requested on this form, please do not hesitate to ask for assistance. We would be happy to help.

Name _____
LAST FIRST INITIAL

Street _____ City _____ State _____ Zip _____

Date of Birth ___/___/___ Age ___ Social Security # _____ Male Female

Cell Phone () _____ Work Phone () _____ Home Phone () _____

E-mail Address _____

Employer _____ Occupation _____

Are you a new patient to our office? Yes No Spouse's Name _____

Did someone refer you to our office? If so, what is their name? _____

Responsible Party If the same as above check here

Name of person responsible for this account _____

Relationship to patient _____ Phone # () _____

Street _____ City _____ State _____ Zip _____

Employer _____ Work Phone () _____ ext _____

Insurance Information

Do you have vision insurance Yes No Do you have health insurance Yes No

If yes, insurance carrier _____ If yes, insurance carrier _____

Name of Insured _____ Relationship to patient _____

Date of Birth ___/___/___ Social Security # _____

Employer _____ Work Phone () _____ ext _____

Insurance Company _____ Group # _____ ID # _____

We will need a copy of both sides of your insurance card, as well as your driver's license.

Fax # 770-426-8157