WELCOME TO

SPRING HILL EYECARE PLLC

See What You've Been Missing!

1. ABOUT YOU

Today's Date:_____/_____/_____

Patient Name:_____
LAST FIRST MI

Preferred Name:_____ ☐Male ☐Female

Title: ☐Mr. ☐Mrs. ☐Ms. ☐Miss ☐Dr. ☐Rev. ☐Other:_____

Birthdate:____/_____/_____ SS#_____-____-_____

Mailing Address:_____

City:_____State:_____Zip:_____

Home Phone #: (_____)_____-_____

Work Phone #: (_____)_____-_____ Ext:_____

Cell Phone #:(_____)_____-_____

E-mail Address:_____

(only list email if we may contact you via email)

Best time/# to reach you:_____

Status: ☐Minor ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Spouse's Name:_____

Employer:_____How long?_____

Employer's Address:_____

City:_____State:_____Zip:_____

Occupation:_____

2. VISION INSURANCE INFO

Primary *VISION* Insurance

Co. Name:_____

Insured's ID#/SS#_____

Group # (Plan, Local, or Policy #):_____

Insured's Name:_____

Relation:_____Birthdate:____/_____/_____

Insured's Employer:_____

Secondary VISION Insurance

Co. Name:_____

Insured's ID#/SS#_____

Group # (Plan, Local, or Policy #):_____

Insured's Name:_____

Relation:_____Birthdate:____/_____/_____

Insured's Employer:_____

3. MEDICAL INSURANCE INFO

Primary *MEDICAL* Insurance

Co. Name:_____

Insured's ID#/SS#_____

Group # (Plan, Local, or Policy #):_____

Insured's Name:_____

Relation:_____Birthdate:____/_____/_____

Insured's Employer:_____

Secondary MEDICAL Insurance

Co. Name:_____

Insured's ID#/SS#_____

Group # (Plan, Local, or Policy #):_____

Insured's Name:_____

Relation:_____Birthdate:____/_____/_____

Insured's Employer:_____

4. IN CASE OF EMERGENCY

Whom should we contact?_____

Relation:_____

Phone #: (_____)_____-_____

Name of Primary Care Doctor:_____

Primary Care Doctor's Office:_____

5. MARKETING INFO

How did you learn about Spring Hill Eyecare, PLLC/Whom may we thank for referring you? (Please check all that apply)

☐ Friend/Family Member(name/relation):_____ ☐ Phone Book(which book?):_____

☐ Another Doctor(name):_____ ☐ Newspaper(which paper):_____

☐ Internet search(which search engine)_____ ☐ Drive-by/Sign

☐ Insurance directory/website:_____ ☐ Other:_____

6. CONSENT

By signing this form, I consent to treatment for myself. I give permission for the doctor(s) to examine, diagnose and initiate treatment as deemed appropriate.

Patient's Signature:_____Date:___/___/_____