LUBBOCK EYE CLINIC

NEW PATIENT INFORMATION

Patient's Name:_____
(Last) (First) (Middle)

Date of Birth:_____/_____/_____ Age:_____ Sex:_____ SSN#:_____

Mailing Address:_____

_____
(City) (State) (Zip)
Permanent Address (if different)_____

_____
(City) (State) (Zip)

Phone: Home (_____) _____-_____ Work: (_____) _____-_____

Patient's Occupation:_____ Employer:_____

Employer's Address:_____

Emergency contact that does not live with you:_____ Relationship:_____

Emergency contact's phone number:_____

Marital Status (circle one) Single Married Widowed Divorced

Spouse's Name:_____

Spouse's Employer:_____

Responsible Party if patient is a minor:_____ Relationship:_____

Address:_____ Phone:_____

Employer:_____ Phone:_____

Source of Referral: Referring Physician Name:_____

----------Reason for Visit----------

Are you here for a Contact Lens Exam? Yes No

Do you wear Contact Lenses? Yes No

What kind? Spherical Toric Gas Perm Bifocal

Contact Lens Exams are not a covered benefit by insurance. Therefore, being the patient's responsibility.

----------Professional Services are non-refundable----------

Workers' Compensation (Job Related Injuries)

If someone other than the patient is responsible for payment:

Employer:_____ Date of Accident_____/_____/_____

Billing Address:_____ Supervisor Name:_____