

# Village Eyes Optometry

## Patient Information

Please fill in the following information so we may prepare your records:

### Please Print Clearly

Patient's Name \_\_\_\_\_  
(Last) (First) (Middle)

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Social Security Number \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Residence street address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell \_\_\_\_\_

E-Mail \_\_\_\_\_

Place of Employment \_\_\_\_\_ Job \_\_\_\_\_

Marital Status: Single \_\_\_ Married \_\_\_ Separated \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Partnered \_\_\_

Children: yes \_\_\_ No \_\_\_ If so, how many? \_\_\_\_\_

Major Medical Insurance \_\_\_\_\_ Supplemental \_\_\_\_\_

Type of Insurance: Traditional \_\_\_ PPO \_\_\_ HMO \_\_\_ Other \_\_\_\_\_

Vision Care Insurance \_\_\_\_\_

Who may we thank for the referral? \_\_\_\_\_

### **PLEASE NOTE: WE DO NOT BILL FOR SERVICES RENDERED**

Person Responsible for Account \_\_\_\_\_

Please check the method of payment for today's professional services:

\_\_\_\_\_ Cash

\_\_\_\_\_ Check

\_\_\_\_\_ Credit Card (MC, VISA, AMERICAN EXPRESS, DISCOVER)

Signature \_\_\_\_\_ Date \_\_\_\_\_