NORTHEAST
EYE CARE

Section 1- Patient Information

Patient Name:_____

Patients Date of Birth:_____ SS#_____ Sex: M F

Patient Address:_____

City:_____State:_____Zip:_____

Home Phone:_____ Cell Phone:_____ Daytime Phone:_____

Email:_____ How did you hear about us? _____

Approved Communication: (circle all that apply) Text Email Postal Phone

Marital Status: (please circle) Single Married Divorced Widowed

Employment/Student Status(circle one):Full or Part Time, Retired, Unemployed, College

Employer:_____Occupation:_____

Section 2- Insurance Information

Medical Insurance: _____Phone#:_____

Member/Subscriber ID:_____Group/Plan #:_____

Vision Insurance:_____ Phone #: _____

Member ID_____ Group/Plan #:_____

Guarantor Information: (Policy Holder) Patient Relationship: (circle) Self Spouse Child Other: _____

Guarantors Name:_____ Sex: Male Female

DOB: _____ SS #: _____ Employer: _____

Guarantor's Address:_____

City: _____ State: _____ Zip: _____

Home Phone:_____ Cell Phone:_____ Day Phone:_____