Family Eye Care of Apex O.D., P.A.

Date:_____

Last Name:_____First Name:_____MI:____

Date of Birth:_____

E-mail Address:_____

Street Address:_____

Mailing Address(if different):_____

City:_____ State:_____Zip Code:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Marital Status: Single Married Divorced Widow
Sex: Male Female

Employer:_____ Occupation:_____

**Insurance Information**: (Please present your card so that a copy can be made for our records.)
Are you the policy holder? ____Yes ____ No
**If No, complete next section**:
Primary Insurance Company Name:_____
Primary Policy Holder's name:_____
Primary Policy Holder's date of birth:_____
Primary Policy Holder's S.S. Number:_____

How did you hear about our Practice? Google New Neighbor Cary Living
Yellowpages.com Current patient other_____

Your preferred method for us to contact you for appointments, optical orders, etc.

e-mail home phone work phone cell phone

(We only use your contact information for direct communication with you.)