



Family Eye Care Group, O.D., P.A.

Date: \_\_\_\_\_  
Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI \_\_\_\_\_  
Date of Birth \_\_\_\_\_

Street Address \_\_\_\_\_  
Mailing Address (if different): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work 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 Name: \_\_\_\_\_

Primary Policy Holder's name: \_\_\_\_\_

Primary Policy Holder's Date of Birth: \_\_\_\_\_

Primary Policy Holder's S.S. Number: \_\_\_\_\_

Whom may we thank for referring you to our practice? \_\_\_\_\_