Welcome to the
Eye Clinic & Contact Lens Center
Dr. Todd J. Lewis & Dr. Andrew T. Smith
Thank you for letting us take care of your eye-care Needs

Today's Date:_____

PATIENT NAME:

Name:_____ Birth Date:_____ SS#:_____
Age:_____ Gender:_____ Home Phone:_____ Cell Phone:_____
Address:_____City:_____ State:_____ Zip:_____
Employer:_____Employer Phone #:_____
Marital Status: Single Married Divorced Separated Widow Child
Email:_____

EMERGENCY CONTACT: **(Nearest relative not living with you)**

Name:_____ Phone:_____
Who may we thank for referring to our office? _____

SPOUSE OR PARENT INFORMATION:

Name:_____ Birth Date:_____ Relationship to Patient:_____
Is this person currently a patient in our office? YES NO
Address: _____ City: _____ State:_____ Zip:_____
Contact Phone #:_____ SS#:_____
Employer Name:_____ Employer Phone #:_____
Email:_____

INSURANCE INFORMATION:

PRIMARY INSURANCE

Name of Insured:_____
Birth Date:_____
Address:_____
(If not same as patient)
Insured ID:_____
Group #:_____
Insurance Company:_____
Insurance Phone #:_____
Employer Name:_____
Relationship to Patient:_____

SECONDARY INSURANCE

Name of Insured:_____
Birth Date: _____
Address:_____
(If not same as patient)
Insured ID:_____
Group #:_____
Insurance Company:_____
Insurance Phone #:_____
Employer Name:_____
Relationship to Patient:_____

I authorize Dr. Todd J. Lewis or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile, or paper form to my insurance carrier or any related entities that require such information to be submitted.

I certify that the above information is correct.

Signature: (Parent/ Guardian if patient is a minor) _____ Date:_____