ALPINE VISION

# Demographics and Insurances

**PATIENT INFORMATION**

First Name _____
Last Name _____
Nickname _____
Street _____
City _____
State _____ Zip Code _____
Home Phone_____
Daytime Phone _____
Cell Phone _____
Email _____

**I agree to be communication** ❑ ALL ❑ NONE
by ❑ Text ❑ Email about ❑ Healthcare ❑ Product/Services
***Healthcare refers to appointment reminders and eyewear notifications.*
***Products/Services refers to promotions, sales, and new services we offer.*

Date of Birth _____
Social Security Number _____
Driver's License Number _____
Expiration _____ State _____

**Gender**
❑ Male ❑ Female

**Marital Status**
❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

**Employment Status**
❑ Employed Full-Time ❑ Employed Part-Time ❑ Retired
❑ Student Full-Time ❑ Student Part-Time ❑ Unemployed
❑ Self Employed ❑ Active Military ❑ _____
Employer _____
Occupation _____

**Emergency Contact** _____
Phone Number _____
Relationship to Patient _____

**Primary Care Practitioner** _____
Phone Number _____

**ROUTINE VISION**

❑ Davis ❑ Eyemed ❑ Spectera ❑ VSP
❑ Other, Name of Insurance _____
Member ID _____
Policyholder _____
Phone Number _____
Date of Birth _____
Social Security Number _____
Relationship to Patient _____

**MAJOR MEDICAL 1**

Name of Insurance _____
Member ID _____
Group ID _____
Policyholder _____
Street _____
City _____
State _____ Zip Code _____
Phone Number _____
Date of Birth _____
Social Security Number _____
Relationship to Patient _____

**MAJOR MEDICAL 2**

Name of Insurance _____
Member ID _____
Group ID _____
Policyholder _____
Street _____
City _____
State _____ Zip Code _____
Phone Number _____
Date of Birth _____
Social Security Number _____
Relationship to Patient _____

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❑ ***Privacy Practices Tips***
** copies available upon request*

❑ ***Contact Lens Agreement***
** contact lens wearers only*

❑ ***Contact Lens Training***

**I have read, understand, and agree to the terms and conditions listed in each of the above documents. I affirm that the above information is true and correct.**

_____ _____

**Patient or Responsible Party's SIGNATURE and PRINTED NAME** **Today's Date**