STEINHAUER FAMILY EYE CLINIC

Referred By _____

☐ Male
☐ Female

☐ Single ☐ Married ☐ Other

Name _____
Last First Middle

Address _____
Street

_____ _____ _____
City State Zip

Telephone _____ Date of Birth _____

Place of Employment _____ Phone _____

Emergency Contact

_____
Name

_____
Address

_____
City

_____
Phone

PAYMENT METHOD:

☐ Credit Card, Check, or Cash

☐ Vision Insurance Type: _____

☐ Quartz

☐ Other Insurance

☐ Medicaid
HMO_____

☐ Medicare