MITCHELL EYE CARE

Welcome To Our Office!

Please complete the following form as thoroughly as possible. The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Information

Last: _____

First: _____MI: _____

Street: _____

City: _____

State: _____

Zip Code: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email Address:

_____

How do you prefer to be contacted?

(Indicate #1 and #2 preference):

Home #___Work #___Cell #___Text___Email____

Patient's SSN:_____

Date of Birth: _____Age: _____

Sex: M F

Employer (or School):

_____

Occupation (or Grade):

_____

Spouse (or Parent's Name):

_____

Spouse (or Parent's Work):

_____

Insurance Information

Vision Insurance:_____

Subscriber Name:_____

Subscriber SSN/ID#:_____

Subscriber Birth Date:_____

Primary Medical Insurance:_____

Subscriber Name:_____

Subscriber SSN/ID #:_____

Subscriber Birth Date:_____

Secondary Medical Insurance:_____

Subscriber Name:_____

Subscriber SSN/ID#:_____

Subscriber Birth Date:_____

Do you participate in a flex spending account?

☐ Yes ☐ No

How Did You Hear About Our Office?

☐ Friend or Relative
☐ Another Doctor
☐ Insurance List
☐ Saw Sign/Building
☐ Newspaper/Radio/TV
☐ Billboard
☐ Facebook/Social Media
☐ Other:_____