

**ARENA EYE SURGEONS
PATIENT INFORMATION**

OFFICE USE ONLY

Acct. No. _____ Doctor _____ Dx _____ Date of Appt. _____

PATIENT INFORMATION PLEASE PRINT Patient Sex: Male Female **Marital Status:** S M D W

Patient Name: _____

Address: _____ FIRST _____ MI _____ LAST _____
Apt. _____ Home Phone: _____ - _____ - _____

City, State, Zip Code: _____ Work Phone: _____ - _____ - _____

Social Security No.: _____ Date of Birth: _____ Cell Phone: _____ - _____ - _____

E-Mail Address (optional): _____ Occupation: _____ FT / PT

Patient Employer: _____ Employer Address: _____

Family Medical Doctor: _____

Who may we thank for referring you to our office? _____

SPOUSE INFORMATION (OR GUARANTOR IF PATIENT IS MINOR) PLEASE PRINT

Name: _____ Date of Birth: _____ Social Security No.: _____

Employer: _____ Employer Phone: _____ - _____ - _____

Employer Street Address: _____ City, State, Zip: _____

EMERGENCY CONTACT (OTHER THAN SPOUSE) PLEASE PRINT

Name: _____ Phone Number: _____ - _____ - _____

Relationship to Patient: _____

INSURANCE INFORMATION: RECEPTIONIST WILL COPY ALL INSURANCE CARDS

PRIMARY

Insurance Co.: _____ Subscriber Name: _____

Subscriber Date of Birth: _____ Relationship to Patient: _____

Policy #: _____ Group #: _____

SECONDARY

Insurance Co.: _____ Subscriber Name: _____

Subscriber Date of Birth: _____ Relationship to Patient: _____

Policy #: _____ Group #: _____

Treatment received by the **ARENA EYE SURGEONS** may include, but is not limited to, dilation, laser surgery, and diagnostic procedures. Vision may be temporarily impaired for driving and or operation of mechanical equipment. Should you have any questions concerning this, please feel free to ask the technician.