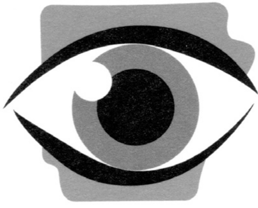

ARKANSAS EYE SITE

Welcome To Our Office!

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

Date: ______________________

Patient Information

Last: ______________________

First: ______________________ MI: __________

Street: ______________________

City: ______________________

State: ______________ Zip code: ______________

Home Phone: ______________________

Work Phone: ______________________

Cell Phone: ______________________

Email: ______________________

SSN: ______________________

DOB: ______________ Age: ______________

Sex: M or F Marital Status: __________

Ethnicity: ______________________

How do you prefer we contact you?

__Home __ Work __Cell __Text __Email

Employer/School: ______________________

Occupation/Grade: ______________________

Spouse/Parent: ______________________

Spouse/Parent work: ______________________

Pharmacy: ______________________

Primary Care Physician: ______________________

Primary Insurance: ______________________

Member ID: ______________________

Group ID: ______________________

Card Holder Name & Date of Birth:

____

Secondary Insurance: ______________________

Member ID: ______________________

Group ID: ______________________

Card Holder Name & Date of Birth:

____

Vision Insurance: ______________________

Member ID: ______________________

Card Holder Name & Date of Birth:

____

Card Holder SSN: ______________________

Are you covered under an employer or union policy?

❑ Yes ❑ No

Are you covered under any other health care plan?

❑ Yes ❑ No

Are you enrolled in a Medicare Advantage Plan?

❑ Yes ❑ No

If not referred, how did you choose our office?

❑ Friend/Relative ❑ Insurance List

❑ Another Doctor ❑ Saw Sign/Building

❑ Newspaper/Radio/TV

❑ Yellow Pages: Directory? ______________

❑ Online search: Where? ______________

❑ Other: ______________________

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the above information.

Signature______________________________ Date: ______________