WELCOME TO OUR OFFICE!

We are pleased to welcome you to **Franklin-Altman Family Eye Care**. Please take a few moments to fill out this form as completely as you can. If you have questions, we will be glad to help you. Please present a copy(ies) of your insurance card

Date _____/_____/_____

Patient Name_____
First Name Last Name

_____(_____)
Middle Initial Goes by

Address_____

City _____

State_____Zip_____

Home Phone _____Preferred Daytime _____

Work Phone_____EXT_____

Cell Phone _____

Email address _____@_____

IN CASE OF EMERGENCY, CONTACT:

Name _____Relationship_____

Home ( ) _____Cell ( ) _____

Work ( ) _____ Ext _____

Patient Information

Sex □ Male □ Female

Birthdate_____**Age** _____

Social Security Number _____

Marital Status □ Married □ Widowed □ Single □ Separated □ Divorced □ Minor

Emloyment Status:

□ Employed Employer_____Full Time/Part Time

Occupation_____

□ Unemployed

□ Retired

□ Student School_____Full Time/Part Time

□ Homemaker

If not "Self" , person Financially Responsible for the patient

_____
First Middle Last

Relationship to patient _____

Address_____

State _____Zip_____Phone_____

Birthdate_____Social Security #_____

Whom may we thank for referring you?_____

Vision Insurance

(if you have no Vision Insurance, skip to Medical Insurance Section)

Insured's Name (Name on Insurance Card)

_____Birthdate_____

Insured's ID #_____

Plan Name □ *VSP* □ *Davis* □ *Spectera* □ *Tenn Care (children)* □ *BlueCross/BlueShield* Other_____

Relationship of Patient to Insured □ Self □ Spouse □ Child

Policy Type □Individual □PPO □HMO

Is Patient covered by additional vision insurance? □*Yes* □*No*

Insured's Name_____Birthdate ___/___/___

Insured's ID #_____

Plan Name □ *VSP* □ *Davis* □ *Spectera* □ *BlueCross/BlueShield* □ *Tenn Care (children)* Other_____

Relationship of Patient to Insured □ Self □ Spouse □ Child

Policy Type □ Individual □PPO □HMO

Medical Insurance

(Many vision complaints/disorders and injuries are covered by your Medical Insurance)

Insured's Name (Name on Insurance Card)

_____Birthdate_____

Insured's ID #_____

Plan Name □ *Medicare* □*United Health Care* □*Tenn Care* □ *Blue Cross/BlueShield* *Other* _____

Relationship of Patient to Insured □ Self □ Spouse □ Child

Policy Type □Individual □PPO □HMO

Is Patient covered by additional or supplemental insurance?
□*Yes* □*No*

Insured's Name_____Birthdate ___/___/___

Insured's ID #_____

Plan Name □ Medicare □ *United Health Care* □ *BlueCross/BlueShield* □*Tenn Care* *Other* _____

Relationship of Patient to Insured □ Self □ Spouse □ Child

Policy Type □Individual □PPO □HMO

Medical/Eye Health Information

Primary Care Physician

Name_____

Phone _____

Date of last visit_____

Date of last eye exam_____

Name of doctor_____

Office Name_____

Pharmacy Information

Pharmacy _____

Phone _____