WELCOME TO OUR PRACTICE

Please fill out the following information completely:

CAROLINA EYECARE PHYSICIANS, LLC

1. Patient Information:

Social Security No: _____ E-Mail Address: _____

Name: (Last) _____ (First) _____ (M.I.) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Sex: M F Marital Status: S M D W

Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Race: ☐ American Indian ☐ Alaska Native ☐ Asian ☐ Black or African American ☐ White
☐ Native Hawaiian or other Pacific Islander ☐ Unknown ☐ Decline to answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to answer

Employed: ☐ No ☐ Full Time ☐ Part Time ☐ Retired Business Phone: _____

Name of Employment or School: _____

2. Guarantor Information: Same as Above: ☐ Yes

If patient is a minor please fill out.

Social Security No: _____ E-Mail Address: _____

Name: (Last) _____ (First) _____ (M.I.) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Sex: M F Marital Status: S M D W

Employed: ☐ No ☐ Full Time ☐ Part Time ☐ Retired Business Phone: _____

Name of Employment or School:

3. Insurance Information:

Primary Insurance: _____ Policy #: _____

Insured's Name: _____ DOB: _____ Insured's SS# _____

Insured's Employment: _____ Work Phone: _____

Secondary Insurance: _____ Policy #: _____

Insured's Name: _____ DOB: _____ Insured's SS# _____

Insured's Employment: _____ Work Phone: _____

4. Appointment Information:

Family Doctor: _____ Referring Doctor's Name: _____

Who is your eye doctor? _____

How did you hear about us? _____

List any family members who are patients: _____

_____

Emergency Contact:

Name: _____ Relationship: _____ Phone No: _____

Pharmacy:

Pharmacy Name: _____ Pharmacy Location: _____

Pharmacy Phone: _____