Levenson eye associates

LevensonEyeAssociates.com | 904-366-3781

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PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Sex: ☐ M ☐ F Relationship to Responsible Party: _____

SSN: _____ Email: _____

Home Phone: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Emergency Contact Phone Number: _____

Employer: _____ Employer Phone Number: _____

Are you a resident of a nursing facility or hospice? ☐ Yes ☐ No

Referring Doctor: _____ Primary Care Physician: _____

INSURANCE

Do you have medical insurance? ☐ Yes ☐ No

Primary Insurance: _____ Secondary Insurance: _____

Policy Number: _____ Policy Number: _____

Group Number: _____ Group Number: _____

Please complete this section if the policy holder is different than patient.

Last Name: _____ First Name: _____

Date of Birth: _____ Social Security Number: _____

COMMUNICATION

Levenson Eye Associates uses an automated patient communication system. Examples of these communications include appointment reminders, reminders to schedule your next appointment and important announcements about our practice.
I authorize **Levenson Eye Associates** to contact me via an automated ☐ phone/ ☐ text/ ☐ email system.

_____ _____

Patient / Parent or Guardian Signature Date