



Elite Vision Care

WELCOME TO OUR OFFICE

Today's Date _____

Patient Name _____ DOB _____ Age _____

Address _____ Apt _____

City _____ State _____ Zip _____

Home Phone (____) _____ - _____ Cell (____) _____ - _____ Work (____) _____ - _____

SSN ____ - ____ - ____ Occupation _____ Employer _____

Email _____

- Yes, send me email reminders No, Please do not send me any emails.
• *Note- Your privacy is important to us; your email address will not be sold.*

What is the purpose of your visit today?

Are you a new patient? If so, who may we thank for referring you to us?

When was your last eye exam? _____ By Whom? _____

Insurance Information

Vision Insurance _____

Subscriber Name _____

Subscriber SSN ____ - ____ - ____ Subscriber DOB _____

Primary Medical Insurance _____

Subscriber Name _____

Subscriber SSN ____ - ____ - ____ Subscriber DOB _____

Do you participate in a flex spending account? Yes No

How will you settle your account today? Cash Check Credit Card