



PATIENT INFORMATION

First Name: _____ M.I.: _____ Last Name: _____
 Home Phone: (____) _____ Work Phone: (____) _____ Ext.: _____
 Street Address: _____ Apt.#: _____
 City: _____ State: _____ Zip: _____
 Sex: Male Female Social Security #: _____
 Marital Status: Single Married Divorced Widow
 Date of Birth ____ / ____ / ____

RESPONSIBLE PARTY:(if other than patient)

First Name: _____ M.I.: _____ Last Name: _____
 Relationship: _____
 Home Phone: (____) _____ Work Phone: (____) _____ Ext.: _____
 Street Address: _____ Apt.#: _____
 City: _____ State: _____ Zip: _____

INSURANCE INFORMATION:

Primary Insurance

Company/Employer Name: _____
 Policy Number: (i.e. soc. sec. #) _____
 Group Number: _____
 Subscriber: _____
 Employee Status: Active Retired Part-time
 Relationship: Self Spouse Parent Guardian

Secondary Insurance:

Company: _____
 Policy Number: (i.e. soc. sec. #) _____
 Group Number: _____
 Subscriber: _____
 Relationship: Self Spouse Parent Guardian

Vision Insurance:

Company: _____
 Policy Number: (i.e. soc. sec. #) _____
 Group Number: _____

REFERRED BY:

Doctor: _____
 Optometrist: _____
 Friend/Relative/Other: _____

Emergency Contact/Nearest Relative

Phone: () _____

I understand that I am responsible for any charges which are not covered by my health insurance, including deductibles and copays. I am the: Patient Parent Guardian

Signature: _____ Date: _____

I authorize insurance benefits to be paid directly to Robert T. Clark M.D. I also authorize medical information to be released to my insurance company (if requested) to process all claims.

Signature: _____ Date: _____