

LUBBOCK EYE CLINIC

NEW PATIENT INFORMATION

Patient's Name: \_\_\_\_\_  
(Last) (First) (Middle)

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Sex: \_\_\_\_ SSN#: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

\_\_\_\_\_  
(City) (State) (Zip)

Permanent Address (if different) \_\_\_\_\_

\_\_\_\_\_  
(City) (State) (Zip)

Phone: Home (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Patient's Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Emergency contact that does not live with you: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency contact's phone number: \_\_\_\_\_

Marital Status (circle one)      Single      Married      Widowed      Divorced

Spouse's Name: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_

Responsible Party if patient is a minor: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Source of Referral: Referring Physician Name: \_\_\_\_\_

-----Reason for Visit-----

Are you here for a Contact Lens Exam?    Yes                      No

Do you wear Contact Lenses?              Yes                      No

What kind?      Spherical      Toric      Gas Perm      Bifocal

*Contact Lens Exams are not a covered benefit by insurance. Therefore, being the patient's responsibility.*

-----Professional Services are non-refundable-----

**Workers' Compensation (Job Related Injuries)**

If someone other than the patient is responsible for payment:

Employer: \_\_\_\_\_ Date of Accident \_\_\_\_/\_\_\_\_/\_\_\_\_

Billing Address: \_\_\_\_\_ Supervisor Name: \_\_\_\_\_