# PATIENT WELCOME FORM

## PATIENT INFORMATION

**Last Name:**_____ **First Name:** _____ **Middle:** _____

| | |
|---|---|
| **Title:** ☐ **Mr.** ☐ **Mrs.** ☐ **Ms.** ☐ **Dr.** | **Marital Status: S/ M / D / W** |
| **Street Address:** | **City/State/Zip Code:** |

| | |
|---|---|
| **Phone #:** ☐ **Home**<br>☐ **Cell**<br>**May we send text messages to this number? Yes** ☐ **No** ☐ | **Last Four of SSN#**<br>**Date of Birth:**<br>**Email:** |
| **Pharmacy Name & Phone #:** | |

## INSURANCE INFORMATION

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|---|---|
| **Name of VISION Insurance:** | **ID Number:** |
| **Name of PRIMARY MEDICAL Insurance:** | **ID Number:** |
| **Name of SECONDARY MEDICAL Insurance:** | **ID Number:** |
| **Subscriber Name:** | **Relationship of Insured/Subscriber to Patient:**<br>**Self** ☐<br>**Spouse** ☐<br>**Child** ☐ |
| **Last four of Social Security #/DOB:** | |

## PROFESSIONAL COMMUNICATIONS

**(Please list the physicians with whom you would like to share exam results)**

| | | |
|---|---|---|
| **Physician Name:** | **Address:** | **Phone #:** |
| **Physician Name:** | **Address:** | **Phone #:** |

## Please let us know how you heard about us!

**Friend / Family:** ☐ **Insurance Website:** ☐ **Gateway:** ☐ **Local Church Bulletin:** ☐

**Google:** ☐ **Facebook:** ☐ **Instagram:** ☐ ☐ **Other:** _____