Eye Clinic of Meridian, PLLC

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Eye Clinic of Meridian • Butler Eye Center • Livingston Eye Center

TODAY'S DATE		
MONTH	DAY	YEAR

PATIENT'S YEARLY INFORMATION SHEET

Patients please complete all questions on this page

PATIENT INFORMATION

Patient's Name ____________________ Area Code ______ Phone # __________________
First Middle Last

Address ______________________ City ____________ State _________ Zip ____________

Sex ___________ Age___________ Date of Birth _______________ Marital Status ________________ Cell Phone # ________________

Social Security # ___________________ Race __________________ Preferred appointment notification: Text☐ Phone Call☐ E-mail☐

E-Mail Address: Yes ☐ No ☐ If yes, please list ______________________________

Employer ______________________________ Area Code ________ Phone # __________________

Employer Address ______________________________

Spouse's Name ______________________ Date of Birth _______________ Social Security # ________________

Spouse's Employer ______________________________ Area Code ________ Phone # __________________

PLEASE COMPLETE THIS SECTION IF PATIENT IS A MINOR

Father's Name/Guardian ______________________ Date of Birth ____________ Social Security # ________________

Address ______________________ City ____________ State _________ Zip ____________
(If different than above)

Father's Employer ______________________________ Area Code ________ Phone # __________________

Employer Address ______________________________

Mother's Name/Guardian ______________________ Date of Birth ___________ Social Security # ________________

Address ______________________ City ____________ State _________ Zip ____________
(If different than above)

Mother's Employer ______________________________ Area Code ________ Phone # __________________

Employer Address ______________________________

INSURANCE INFORMATION

Do you have medical insurance? Yes ☐ No ☐ Medicare? Yes ☐ No ☐ Medicaid? Yes ☐ No ☐

Primary Insurance Company ______________________________

Insured Name ______________________ Date of Birth ________________ Relationship ______________________

Policy Number ______________________________ Group Number ____________________

Secondary Insurance Company ______________________________

Insured Name ______________________ Date of Birth ________________ Relationship ______________________

Policy Number ______________________________ Group Number ____________________

I certify that this information is correct and I will be responsible for payment of services rendered. ______________________
Signature

Name & relationship to patient, if not patient or legal guardian. ______________________________