INDIANAPOLIS VISION CARE
ENHANCING VISION FOR LIFE

Patient Information Record

Patient's Last Name_____ First Name _____ MI _____

Address _____City _____ State _____ZIP _____

Home Phone _____ Work Phone _____

Cell Phone _____ E-mail _____

How do you prefer we contact you?

☐ Work phone ☐ Cell phone ☐ Email ☐ Any of these options

Social Security No. _____ Birth Date _____ Sex ☐ M ☐ F Age _____

Occupation & Employer _____

(if student, list grade, school name)

Marital Status _____

Name of Spouse or Nearest Living Relative _____ Relationship _____

Phone Number _____ Address (if different that above) _____

Date of last eye exam _____

Do you wear…? Glasses Contact Lenses

Are you interested in…?

☐ Glasses ☐ Contact lenses ☐ Vision correction surgery ☐ Other _____

How did you hear about our office?

☐ Referral Whom may we thank for the referral? _____

☐ Google ☐ Instagram ☐ Local Advertising ☐ phone book ☐ Other_____

☐ Facebook ☐ Twitter ☐ Insurance provider ☐ Yelp

Who will be responsible for the financial aspects of this case? (Check all that apply)

Patient Parent/Guardian Insurance Other _____

If patient is under the age of 18: Signature of parent or guardian authorizing treatment _____

Name of insurance policy holder (if different from patient) _____

Date of birth of policy holder _____

Thank you for your cooperation. Please complete form on the back side of this page.

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