Milam's
COMMUNITY EYE CARE
770 483-4831

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we will be glad to help you.

PATIENT INFORMATION

Name: _____ Sex: _____ Age: _____

Address: _____ Birthdate: _____

City, State, Zip: _____ SSN: _____

Home Phone: _____ Work Phone: _____ ext. _____ *Cell Phone: _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced Spouses Name: _____

Email: _____

Occupation: _____ Employer: _____

Work Address: _____City, ST:_____ Zip: _____

OPTIONAL

Do you wear glasses? ☐ Yes ☐ No How often _____

Do you wear contacts? ☐ Yes ☐ No How often _____ What brand? _____

Reason for visit today?: _____

MEDICAL & INSURANCE INFORMATION

Medical Insurance: _____ Vision Insurance: _____

Please list primary on insurance (if other than you) _____ DOB _____ Last 4 of SSN:_____

ACCOUNT RESPONSIBLE

Name: _____ Address: _____

City, State, Zip: _____

Work:_____ext_____ Cell Phone:_____

EMERGENCY INFORMATION

Friend or Relative Not Living at Home:

_____

Daytime Phone Number:

_____

Other Emergency Phone Number:

_____

REFERRED BY

☐ Employer ☐ Friend ☐ Doctor

☐ Insurance ☐ Family Member

☐ Yellow Pages ☐ Location

☐ Other (please specify on line below)

_____

☐ Check this box if this individual is a Milam's patient