



VisionFirst Eye Center
First in Total Eye Care

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PATIENT INFORMATION SHEET

Date Completed: _____

HOW DID YOU HEAR ABOUT US? WDJC Billboard Newspaper Yellow Pages
 Info received in the mail Community Event Friend Doctor referral Other _____

PATIENT NAME (First) _____ (MI) _____ (Last) _____

Street Address _____

City _____ State _____ Zip _____ Email _____

Home Phone _____ Alternate (cell/work) Phone _____

Birthdate ____/____/____ SSN _____ - _____ - _____ Sex _____

Marital Status _____ Spouse name _____

Occupation _____ Employer/School Name _____

EMERGENCY CONTACT INFORMATION

Name _____ Home Phone _____

Relationship to Patient _____ Alt Phone _____

Primary Care Phys _____ Referring Phys _____

INSURANCE INFORMATION (Please allow us to make copies of your insurance cards)

PRIMARY INSURANCE COMPANY _____ **Copay Amt \$** _____

Policy Holder Info (*Check here if same as patient* *and skip to Secondary Insurance info*)

Name _____

Address _____

Date of Birth ____/____/____ SSN _____ - _____ - _____ Relation to Pt _____ Sex _____

Occupation _____ Employer _____

SECONDARY INSURANCE COMPANY _____ **Copay Amt \$** _____

Policy Holder Info (*Check here if same as patient* *and skip to Vision Plan info*)

Name _____

Address _____

Date of Birth ____/____/____ SSN _____ - _____ - _____ Relation to Pt _____

Sex _____ Occupation _____ Employer _____

VISION PLAN _____ **Copay Amt \$** _____

Policy Holder Info (*Check here if same as patient*))

Name _____

Address _____

Date of Birth ____/____/____ SSN _____ - _____ - _____ Relation to Pt _____

Sex _____ Occupation _____ Employer _____