Appointment Time:

Patient Information Form

Dr. Adcox Total Vision Center thanks you for choosing our office. Please completely fill out this form to ensure the fastest and best healthcare services. We may ask you to look over this information from time to time to ensure it stays up to date.

Patient Name: ______________________________________ Date of Birth __________________________

Social Security Number: ______________________________ Home number_________________________

Address: ____ Cell number: __________________________

____ E-mail:_______________________________

Please Circle one:

Glasses

Contacts

Insurance Company name and policy number Primary ____ ____	Insurance Company name and policy number Secondary ____ ____

If you are covered under the insurance of another party (**not you**) please complete next section:

Name: ____ DOB: _______________________________

Social Security Number:_________________________________ Phone number:________________________

Address: ____ Relation to the patient_________________

____

Are you currently being treated for any medical conditions? Please list ANY below. If you are currently being treated for Diabetes please list which type you are being treated for:

____

____

List of all current medications:____

____

____

Office staff will complete remainder of form

(Staff please complete following)

Last RX:

OD:
OS:

Circle one:

New Patient

Established Patient