# DOWNTOWN'S VISION CARE

Please Print Clearly

## Patient Information

Name: _____ DOB: _____ Date: _____

Sex: ☐ M ☐ F Last 4 digits of Social Security #: _____

Address: _____ City: _____ Zip Code: _____

Phone / Email: Pref: ☐ Home ☐ Work ☐ Cell ☐ Email

Home: _____

Work: _____

Cell: _____

Email: _____ ☐ Declined to provide Email

## Insurance Information

Company: _____

Subscriber/Member ID #: _____

Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

If other than Self:

Policy Holder's Name: _____

Policy Holder's DOB: _____

## Secondary Insurance or Vision Plan

Company: _____

Subscriber/Member ID #: _____

Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

If other than Self:

Policy Holder's Name: _____

Policy Holder's DOB: _____

**Current Vision Concerns**: _____

**Currently wears**: ☐ Glasses ☐ Contacts ☐ None