Family Eye Care Clinic P.C.
Modern Technology with Old Fashioned Caring

Dr. Randal M. Cox
Dr. Terry D. Foster
Dr. Adam R. Cox
Therapeutic Optometrists

WELCOME

Thank you for choosing our practice for your eye care needs. Please take a few minutes to fill out this form as completely as you can. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Patient Information

❑ Mr. ❑ Mrs. ❑ Ms ❑ Other

Name _____ Preferred Name _____ Birthdate ____/____/____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone#_____ Cell Phone # _____

Email:_____ Confirm Email:_____

Preferred method of contact: ❑ Email ❑ Phone ❑ Text

Social Security# ____/____/____ Birth State _____ Race: ❑White ❑African American ❑Hispanic ❑Other

Employer _____ Occupation _____

If Married, Name of Spouse _____ Spouse's Employer _____

If Child, Father's Name _____ Mother's Name _____ Mother's Maiden Name_____

Have we previously seen any members of your household? ❑ Yes ❑ No

If so, name and relationship to patient _____

Whom may we thank for referring you to us?_____

Responsible Party

Name of person responsible for this account _____

Relationship to patient _____ Phone #_____

Address_____ City _____ State _____ Zip _____

Insurance Information

Do you have Vision Care Insurance? ❑ Yes ❑ No Name of Insurance _____

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security #_____ Name of Employer _____

Do you have Medical Insurance? ❑ Yes ❑ No Name of Insurance _____

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security #_____ Name of Employer _____

Todays Visit

What is the purpose of this visit?_____

Are you interested in wearing contact lenses? ❑ Yes ❑ No

Any problems with your present glasses or contact lenses?_____

Please check preferred method of payment ❑ Cash ❑ Check ❑ Visa/MasterCard ❑ Discover

PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED.

THANK YOU