TILLAMOOK VISION CENTER

Date:

PATIENT INFORMATION

Patient's Last Name:		**First:**		**Middle:**	
Preferred name:				Last Four of SSN:	
Date of Birth:		Gender:	☐ M ☐ F		
Email address:					
Mailing Address:		City, State, ZIP:			
Physical (if different):		City, State, ZIP:			
Primary phone:		☐ Cell ☐ Home ☐ Work			
Secondary Phone:		☐ Cell ☐ Home ☐ Work			
Occupation:		Employer:			
Other family members seen here:					

INSURANCE INFORMATION

Subscriber Information ***(If not the patient)***

Name:		DOB:	Phone: *(if different)*
Address: *(if different)*			Employer:
Is the subscriber a patient here? ☐ Y ☐ N		Patient's relationship to subscriber:	

Primary *MEDICAL* Insurance

Insurance Company:			
Member ID #:		Group #:	

Secondary *MEDICAL* Insurance

Insurance Company:			
Member ID #:		Group #:	

***VISION* Insurance**

Insurance Company:			
Member ID #:		Group #:	

IN CASE OF EMERGENCY

Emergency contact:		Phone:	
Relationship to patient:			

TILLAMOOK
VISION CENTER

Guarantor Information			
If the patient is a child, please complete the next section			
Guarantor:	☐ **Mother** ☐ **Father** ☐ **Other** _____		
Mother's Name		**Father's Name**	
Date of Birth		**Date of Birth**	
Cell Phone		**Cell Phone**	
Employer		**Employer**	
Occupation		**Occupation**	
Address **(If different from child)**		**Address** **(If different from child)**	

Is the above information correct for other children in the same family? ☐ Yes ☐ No

- I attest the above information is correct.
- I authorize release of my child's exam results to his/her school.

X_____

Guarantor Signature