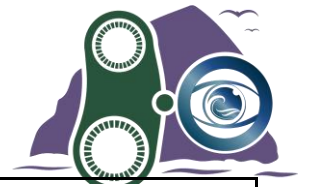


TILLAMOOK VISION CENTER



Date:					
PATIENT INFORMATION					
Patient's Last Name:		First:		Middle:	
Preferred name:				Last Four of SSN:	
Date of Birth:		Gender:	<input type="checkbox"/> M	<input type="checkbox"/> F	
Email address:					
Mailing Address:		City, State, ZIP:			
Physical (if different):		City, State, ZIP:			
Primary phone:	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work				
Secondary Phone:	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> 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? <input type="checkbox"/> Y <input type="checkbox"/> N			Patient's relationship to subscriber:		
Primary <u>MEDICAL</u> Insurance					
Insurance Company:					
Member ID #:		Group #:			
Secondary <u>MEDICAL</u> Insurance					
Insurance Company:					
Member ID #:		Group #:			
<u>VISION</u> Insurance					
Insurance Company:					
Member ID #:		Group #:			
IN CASE OF EMERGENCY					
Emergency contact:				Phone:	
Relationship to patient:					



Guarantor Information

If the patient is a child, please complete the next section

Guarantor:	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> 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