Insurance & Medical Information

Patient Name ____

Birthdate ____________ **Social Security #** _______________

Medical Insurance

Name of Insurance ___________________________________
(Such as Blue Cross, Medicare, United Health Care, etc…)

Name of Insured ____________________________________
(Name on Card)
Contract Number __________________**Group #**___________

Vision Insurance

Name of Insurance ____________________________________
(Such as Vision Service Plan, Eye Med, Spectera, etc…)

Name of Insured ______________________________________
(Name on Card)
Contract Number _________________**Group #**____________

Who is your primary care physician? ____________________

Please list below any medications that you are currently taking and what you are taking it for.

Medication	Purpose	Medication	Purpose