

BURCHAM EYECARE CENTER
Patient Information (Please print clearly)
Complete all appropriate sections and sign and date at bottom

Personal Information

Married Single Other Mr. Mrs. Ms. M or F
First Name _____ Middle Initial _____ Last Name _____
Mailing Address _____ Apt # _____
City _____ State _____ Zip Code _____
Phone: Home _____ Work _____
Cell Phone: _____ Employed None FT PT Retired
Employed by _____ Occupation _____
Date of Birth _____ Current Age _____ SS# _____
Email Address _____

Complete if patient is under 18 years of age or a student:

Name of Father _____ Father Employer _____
Work Number _____ Name of Mother _____
Mother's Employer _____ Work Number _____
Person Responsible for Bill: _____
Billing Address if different than patient's
address _____

Insurance Information

Medical Insurance: Primary _____ Secondary (if any) _____
Name of Primary Insured: _____
Routine Vision Insurance: _____
Primary Member: Name _____ DOB: _____
SS# _____

Workmen's Compensation (if treatment is for job related injury):

Date of Injury _____ Employer _____
Employer Contact Name _____
Phone # _____
Name of Carrier _____ Claim # _____
Address Claim should be
mailed: _____

Emergency Notification

Name _____ Relationship _____
Address _____
Home Number _____ Work Number _____

Patient or Parent Signature _____ Date _____

Who can we thank for referring you to our office: _____