Goldsmith eye care

Date	E Mail Address		
Last Name	First Name	Middle Initial	Nickname
Address	City	State	Zip Code
Marital Status □ S □ M □ D □ W □ Sep	Birth Date / Age	Preferred Pronoun	Social Security No
Home Phone	Cell Phone	Gender (needed for insurance purposes) □ M □ F	
Employment Status □ FT □ PT □ Temp □ Student □ Retired	Employer Name or School Name		
Name of Family Doctor and Location		I heard about this clinic from: □ Internet □ Mailing □ TV □ Radio □ Patient □ Other _____ Patient/Other	
Pharmacy Name and Location	Patients Occupation		
Guarantor's Name & Phone (if minor)	Guarantor's Birth Date (if minor)		

NOTIFY IN CASE OF EMERGENCY (OTHER THAN SPOUSE AND OTHER THAN YOUR ADDRESS)

Name	Relationship	Phone Number	
Address	City	State	Zip Code

INSURANCE INFORMATION

1) Primary Insurance Name		**Insurance Coverage Start Date**		Employment Status of Insured – Check One ϒ Full-Time Employment ϒ Part-Time Employment ϒ Full-Time Student ϒ Part-Time Student ϒ Not Employed ϒ Self-Employed ϒ Retired ϒ Active Military Duty ϒ Unknown
Policy No.		Group No.		
Subscriber Name		Subscriber Birthdate		
Address (if different from above)				
City	State	Zip Code	Home Phone	
Patient Relationship to Subscriber of Insurance		Employer Name/School Name of Insured		
2) Secondary Insurance Name				Insurance Coverage Start Date
Policy No.		Group No.		
Subscriber Name		Subscriber Birthdate		Patient Relationship to Subscriber of Insurance