South Shore Eye Care LLP

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Wantagh, NY 11793
p 516-785-3900
f 516-783-0033

689 Broadway
Massapequa, NY 11758
p 516-541-4141
f 516-541-4150

Date :_____

PATIENT INFORMATION

PATIENT NAME _____

ADDRESS: STREET _____

CITY/STATE/ZIP _____

PHONES: HOME _____ WORK _____ CELL _____

PREFERRED METHOD OF CONTACT: *(Please check all that apply)* ❑ HOME | ❑ WORK | ❑ CELL: ❑ Text ❑ Voice

EMERGENCY CONTACT _____
(NAME) (PHONE) (RELATIONSHIP)

E-MAIL ADDRESS _____

DATE OF BIRTH _____ / _____ / _____ AGE _____ SEX: ❑ M ❑ F

SOCIAL SECURITY NUMBER _____

NAME OF SPOUSE/PARENT/GUARDIAN _____

PRIMARY CARE PHYSICIAN: NAME _____

ADDRESS _____ PHONE _____

PHARMACY NAME/PHONE NUMBER _____

REFERRED BY _____

POLICYHOLDER INSURANCE INFORMATION

PRIMARY INSURANCE _____

INSURED NAME _____

INSURED SEX: ❑ M ❑ F | DATE OF BIRTH _____ / _____ / _____ SS# _____

RELATIONSHIP TO PATIENT _____

INSURED'S EMPLOYER _____

SECONDARY INSURANCE _____

INSURED NAME _____

INSURED SEX: ❑ M ❑ F | DATE OF BIRTH _____ / _____ / _____ SS# _____

RELATIONSHIP TO PATIENT _____

INSURED'S EMPLOYER _____

PREFERRED LANGUAGE _____ RACE _____ ETHNICITY _____

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