C&C vision gallery

Get Acquainted Form

Patient Information

First Name _____ MI _____ Last Name _____ ☐ Male ☐ Female _____ / _____ / _____ Date

Street Address _____ City _____ State _____ Zip Code _____

Date of Birth _____ / _____ / _____ Social Security Number _____ – _____ – _____ Home Phone _____ Work Phone _____

Place of Employment _____ Occupation _____

Patient's Status: ☐ Single ☐ Married ☐ Other ☐ Student

Who may we thank for referring you to our office? _____

Would you prefer to receive appointment reminders via text message or email? ☐ Yes ☐ No

Email Address _____ Cell Number _____

Primary Insurance Information

We must have a current copy or your insurance card and request that all information is completed or your insurance will not be billed. If the insured is under 18 years of age, then we must have the guardian's information below.

Name of Medical Insurance _____ Name of Vision Insurance _____

Insured's Name _____ Insured's Date of Birth _____ / _____ / _____ Insured's Social Security Number _____ – _____ – _____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Guardian's Name _____ ☐ Same as Insured Guardian's Date of Birth _____ / _____ / _____ Guardian's Social Security Number _____ – _____ – _____

If you have a Secondary Insurance please list it here: _____ Name of Insurance _____ Insured's Name _____ / _____ / _____ Date of Birth

Patient Demographics

Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Race: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Native Hawaiian ☐ Pacific Islander

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander

(Please see other side)