

Welcome to Caplan Eye Clinic
Please Print All Responses

New Patient_____ Update_____

Patients Name:_____

Last

First

Middle

Home Address:_____

Street # and Name of Street

Apt # if any

City

State

Zip Code

Home Phone_____ Business Phone_____

Date of Birth (m/d/y) _____ Social Security Number_____

Email (used ONLY to communicate with patients)_____

Place of Employment_____

Employment Address_____

Occupation/Job Position_____

Marital Status: (please circle one) single married divorced widowed

Name of Spouse (if married) or Parent (if minor)_____

Employment/Address of Spouse/Parent_____

Referred by: _____

Nearest Relative not Living with You_____

ARE YOU INTERESTED IN LASER VISION CORRECTION (LASIK): _____

Medicare #_____

Medicare Supplemental_____

Other Insurance, PPO, HMO_____

I authorize payment of medical bene fits to named provider for professional services rendered. I authorize release of any medical information necessary to process claims.

_____ Date

_____ Patient Signature

Office Policy: Payment is required prior to each visit, including payment of all deductibles, co-payments, non-covered services.