MargolisVision

State-of-the-Art Center for
Medical, Surgical & Cosmetic Ophthalmology

Patient Information

Thank you for choosing Margolis Vision for your eye care needs. Please fill out this form and bring it with you to your appointment, along with photo ID and your insurance card(s).

Date: _____

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work/Cell Phone: _____

Social Security #:_____ Sex: M F Email Address: _____

Insurance Provider: _____ Do you have vision insurance? YES NO

Secondary/Vision Provider: _____

Responsible Party Information (optional):

Name: _____ DOB: _____

Relationship to the patient: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work/Cell Phone: _____

Social Security #:_____ Sex: M F Email Address: _____

Same as Emergency Contact? YES NO If no, please indicate Emergency Contact on back.

Please sign below if we may disclose protected health information to your responsible party:

Patient Signature: _____

Witness Signature: _____