Linda R. Price, O.D.

Patient Information:

Date: _____

Patient's Full Legal Name: _____ DOB:_____ Sex: ☐ M ☐ F

SS#: _____ Race: _____ Ethnicity: _____ Marital Status: _____

Patient's Address: _____ City: _____ State: _____ Zip Code: ____

Home Phone: _____ Cell Phone: _____ Daytime Phone: _____

Email: _____

Employment/Student Status: (check one) ☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Student

Employer: _____ Occupation: _____

How did you hear about us? _____

Insurance Information:

Medical Insurance: _____ Phone #: _____

Member/Subscriber ID #: _____ Group/Acct #: _____

Vision Insurance: _____ Phone #: _____

Member ID #: _____ Group/Plan #: _____

* *If you are not the guarantor/primary policy holder, please enter that individual's information below:*

Primary's Name: _____ Relationship to Patient: (check one) ☐ Spouse ☐ Parent ☐ Other

DOB: _____ SS#: _____ Sex: ☐ M ☐ F Employer: _____

Patient's Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Daytime Phone: _____

Please note that the above information is required in order for us to file your examination to your insurance. Please do not leave any section blank as it will delay filing your insurance and may result in a denial from your insurance company.

We apologize that our office is not able to accommodate children while parents are being examined. With respect for other patients in the waiting area, please arrange for childcare outside of our office during your appointment.