❑ Ms.❑ Mrs. ❑ Mr. ❑ Dr.

Name: _____ ❑ Male ❑ Female

Address: _____ ❑ Single ❑ Married ❑ Life Partner

City, State, Zip: _____ Date of Birth: _____

Preferred Phone #: _____ ❑ Home ❑ Cell ❑ Work

Alternate Phone #: _____ ❑ Home ❑ Cell ❑ Work

Email: _____

SSN: _____

Parents (if minor): _____

Occupation: _____

Employer: _____ If Student: ❑ Full Time ❑ Part Time

How did you hear about Blink Eyecare? _____

Insurance Information:

Vision Insurance: _____ Contract/Policy #: _____

Subscriber: _____ Subscriber's Date of Birth: _____

Subsciber's Address if different from patient: _____

Medical Insurance: _____ Contract/Policy#:_____

Subscriber: _____ Subscriber's Date of Birth: _____

Subscriber's Address if different from patient: _____

In order to bill medical insurance, card must be present at time of appointment

The following information is requested in order to comply with healthcare guidelines:

Preferred Language: ❑ English ❑ Spanish ❑ Other

Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ White

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino