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## PATIENT INFORMATION FORM

MR. / MRS. / MS.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI \_\_\_\_\_

Marital Status: Married Single / Separated Widowed Divorced

Address: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Street City State Zip

Home Phone: (\_\_\_\_) \_\_\_\_\_ Bus. Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: Male Female

EMAIL Address: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Name & Address: \_\_\_\_\_

Emergency Contact (Name, Phone No. & Relationship): \_\_\_\_\_

Name of Medical Doctor: \_\_\_\_\_ Referred by: \_\_\_\_\_

Do you have Insurance, including Medicare, which may cover any part of your visit? Yes No

If Yes, Name of Insurance Co.: \_\_\_\_\_

Does your insurance require you to receive a referral from your primary care physician? Yes No

### ***PLEASE ALLOW US TO MAKE COPIES OF YOUR INSURANCE CARD(S).***

If patient is not responsible for payment, please indicate who is: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Day Time Phone#: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Is your insurance coverage through **You** or **Your Spouse/ Guardian?** (please check one); if insurance is through your Spouse or Guardian, please fill out information below:

Name of Insured: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Employer: \_\_\_\_\_ Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Does this plan cover Medical and Vision Care? Yes No

If you have separate Vision coverage, please list name of **Vision Plan**: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**For Office Use Only: Initial and Date each time reviewed:** \_\_\_\_\_