

**ARENA EYE SURGEONS  
PATIENT INFORMATION**

**OFFICE USE ONLY**

Acct. No. \_\_\_\_\_ Doctor \_\_\_\_\_ Dx \_\_\_\_\_ Date of Appt. \_\_\_\_\_

**PATIENT INFORMATION    PLEASE PRINT    Patient Sex:** Male Female    **Marital Status:** S M D W

Patient Name: \_\_\_\_\_

Address \_\_\_\_\_ FIRST \_\_\_\_\_ MI \_\_\_\_\_ LAST \_\_\_\_\_  
Apt. \_\_\_\_\_ Home Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_ Work Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Drivers License No. \_\_\_\_\_ Social Security No. \_\_\_\_\_ Birthdate \_\_\_\_\_

E-Mail Address (optional) \_\_\_\_\_ Occupation \_\_\_\_\_ FT / PT

Patient Employer \_\_\_\_\_ Employer Address \_\_\_\_\_

Family Medical Doctor \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

**SPOUSE INFORMATION (OR GUARANTOR IF PATIENT IS MINOR)    PLEASE PRINT**

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security No \_\_\_\_\_

Employer \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Employer Street Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

**EMERGENCY CONTACT (OTHER THAN SPOUSE)    PLEASE PRINT**

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

**INSURANCE INFORMATION:    RECEPTIONIST WILL COPY ALL INSURANCE CARDS**

**PRIMARY**

Name of Insurance Co. \_\_\_\_\_ Name of Policy Holder \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**SECONDARY**

Name of Insurance Co. \_\_\_\_\_ Name of Policy Holder \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Treatment received by the **ARENA EYE SURGEONS** may include, but is not limited to, dilation, laser surgery, and diagnostic procedures. Vision may be temporarily impaired for driving and or operation of mechanical equipment. Should you have any questions concerning this, please feel free to ask the technician.