

Welcome to Cary Optometric, PA

PATIENT INFORMATION			
Patient's Last Name:		First:	MI: Nickname:
Home Address:		City, ST Zip:	
Phone: (check preferred) <input type="checkbox"/> Hm: <input type="checkbox"/> Cell: <input type="checkbox"/> Wk:			
Email Address:		DOB:	Sex: Marital Status: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other
SS#:	Employer/School:		Occupation/Grade:
Billing Address (if different):			
Why did you choose our office? <input type="checkbox"/> Website <input type="checkbox"/> Location <input type="checkbox"/> Ins. Plan <input type="checkbox"/> Other <input type="checkbox"/> Referred by:			
Parents/guardians if patient is a minor		Other family members seen at this office:	
Primary Physician:		Practice Name and Phone:	
Previous Eye Doctor:		Address and/or phone (if CL RX or records of a medical condition are needed)	
Race: <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Native American/Alaskan <input type="checkbox"/> White <input type="checkbox"/> Decline			
Ethnicity: <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Decline		Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish	

INSURANCE INFORMATION			
Please note: Most "Vision" plans only cover refractions and routine, non-medical eye exams. Visits involving medical problems such as conjunctivitis, dry eye, ocular injuries, cataracts, glaucoma, macular degeneration, sudden pain or vision loss or monitoring for ocular side effects of chronic diseases such as diabetes and hypertension fall under your medical insurance coverage, not your "vision" plan. Some Well Vision Plans will apply your benefits toward medical co-pay and deductibles and some do not. If you have any questions about your coverage, be sure to contact your insurance company before your scheduled appointment.			
Medical Insurance Carrier:		ID#	Policy/Group #
If the patient is NOT the insured, please fill out the following information for the INSURED:			
Name:		DOB:	SS #: Patient's relation to insured: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Address (if different):			Phone:
Vision Plan:		ID#:	Policy/Group #:
If the patient is NOT the insured, please fill out the following information for the INSURED:			
Name:		DOB:	SS #: Patient's relation to the insured: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Address (if different):			Phone:

Marcia Dettloff, OD