

PATIENT INFORMATION**SINGER EYE CENTER****Jack A. Singer, M.D.**

Patient Name (First)	(M)	(Last)	By what name do you wish to be called?		
<input type="checkbox"/> Male	Date of Birth	<input type="checkbox"/> Single	<input type="checkbox"/> Widowed	Social Security #	
<input type="checkbox"/> Female	Mo Day Yr	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Separated	
Local Address	City	State	Zip	Phone # ()	
Out of Town Address	City	State	Zip	Phone # ()	
Email Address (s)					
Employer (If currently employed)			Your occupation (former if retired)		
Employer's Address	City	State	Zip	Phone # ()	
Spouse's Name (First)	(M)	(Last)	Spouse's Social Security #		
Spouse's Employer (If currently employed)			Spouse's occupation (former if retired)		
Responsible Party's Name (if other than self) (First)		(M)	(Last)	Relationship to Patient	
Responsible Party's Address	City	State	Zip	Phone # ()	
Responsible Party's Employer (if other than Self)			Responsible Party's Social Security # (if other than Self)		
Name of Emergency Contact NOT at Your Address		Phone # ()	Primary Care Physician ("PCP")		

INSURANCE INFORMATION

Primary Insurance				Secondary Insurance			
Name of Insured		Insured's DOB		Name of Insured		Insured's DOB	
Social Security or Policy #		Group #		Social Security or Policy #		Group #	
Address of Insurance Company				Address of Insurance Company			
City		State	Zip	City		State	Zip
Auto Accident? Yes or No	Date Occurred	Insurance Co.		Claim #			
Workman's Comp?	Date Occurred	Insurance Co.		Contact Person			

HOW DID YOU HEAR ABOUT US?

My Physician/Optomtrist referred me: _____		Physician/Optomtrist's name	
A friend _____		Newspaper ad _____	
A relative _____		Newspaper article _____	
One of our patients _____		Yellow pages _____	
The internet _____		Insurance list _____	
Vermont Public Television _____		Emergency/On call _____	
WNNE or WPTZ TV _____		Other _____	