

SOUTH FLORIDA EYE CARE CENTER

Office of Drs. Furnari and Lofton

PATIENT INFORMATION: PLEASE PRINT

Today's Date ____/____/____

Patient's Name _____ Age _____ Date of Birth ____/____/____

Title: Mr. Mrs. Miss Miss Dr. Other _____ Gender: Male Female

Name of Spouse _____ If Minor, Parent's Name _____

Address _____ Apt /Lot _____

City _____ State _____ Zip code _____

Home Phone _____ - _____ - _____ Cell ph. _____ - _____ - _____ Alt _____ - _____ - _____

E- Mail Address _____

Place of Employment/School _____ Occupation _____

Social Security # (Needed to Verify Insurance) _____ - _____ - _____

Vision Insurance? Yes No

Medical Insurance? Yes No

PLEASE PROVIDE INSURANCE CARDS & PICTURE ID TO KEEP ON FILE

Date of last eye exam: ____/____/____

Do you wear glasses? Yes No

Are you wearing contact lenses? Yes No

Are you interested in wearing contact lenses?..... Yes No

Are you interested in Laser Vision Correction? Yes No

Any special eye or vision problems?..... Yes No

If yes, please specify _____

Reason for today's visit _____

How were you referred to our office? _____

Primary Care Physician _____ Ph. _____ - _____ - _____

I acknowledge that I received a copy of Drs. Furnari and Lofton's Notice of Privacy Practices.

Signature _____ Date ____/____/____

948 N. Krome Avenue, Homestead, Florida 33030 ▪ Tel. 305-247-2331 ▪ Fax 305-248-7904 ▪ dr814@bellsouth.net