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 _____/_____/_____

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