Welcome to DECATUR FAMILY EYE CARE!

Dr. Jonathan Davis **Dr. Jessica Coggin**

Patient Information: **Please complete the following and bring to your appointment**

Name:			Date:	
Date of Birth:	Age:		Primary Phone:	
Billing Address:	City:		State:	Zip Code:
Email:	Cell Phone:			
Social Security #:				
Emergency Contact:				
Name:	Address:			
Phone:	Relation to Patient:			
Can We Release Medical Information to This Person? YES_____ NO_____				
Primary Care Physician: or circle: Do Not Have One				
Pharmacy (Local):	Pharmacy (Mail-order):			
*Have you had any NEW medical diagnoses since your last appointment? If YES, please list. ______				
*Have you had any changes in your medications since your last appointment? If YES, please list. ______				

Medical/Vision Insurance information. It is your responsibility to notify us of any changes. If unable to verify insurance information, the patient will be responsible for all charges.

Medical Insurance

Insurance Name:	Policy #:	
Policy Holder's Name:	DOB:	Social Security #: ___________

Vision Insurance

Insurance Name:	Policy #:	
Policy Holder's Name:	DOB:	Social Security #:___________

Do you have a Secondary Insurance? Yes____ No____

Secondary Insurance Name:	Policy #:	
Policy Holder's Name:	DOB:	Social Security #:___________

Your Vision Insurance does not cover additional medical testing, foreign body removal, infections of the eye, etc. These services may be subject to your Medical Insurance deductibles and/or copays. Your Medical Insurance is needed on file for matters such as this.

PLEASE PROVIDE THE FRONT DESK WITH YOUR PICTURE ID AND INSURANCE CARDS.