865 Eisenhower Blvd.
Johnstown, PA 15904

Vision Care Specialists
FAMILY EYECARE

Phone: (814) 266-8840
Fax: (814) 266:4928

Patient Information

Patient Name:_____ DOB:_____
Address:_____ Age: ____ SSN#_____
City:_____ ST_____ ZIP_____ County:_____
Home Phone:_____ Cell Phone:_____
Primary Care Physician & Practice Name:_____

Parent / Guardian Information

Father / Guardian Name:_____ Employer _____
Address:_____ DOB:___/___/_____ SSN#_____
City:_____ ST _____ ZIP_____ Cell Phone: _____
Home Phone:_____ Work Phone:_____

Mother / Guardian Name:_____ Employer _____
Address:_____ DOB:___/___/_____ SSN#_____
City:_____ ST _____ ZIP_____ Cell Phone:_____
Home Phone:_____ Work Phone:_____

Insurance Information

Vision Insurance Name _____ID# _____Group# _____

Primary Medical Insurance _____ID# _____Group# _____

Secondary Medical
Insurance_____ID#_____Group#_____

Emergency Contact information (Other than primary residence)

Name*_____Relationship*_____

Home Phone*_____ Work Phone_____

Cell Phone*_____

I acknowledge that all information provided is true and accurate. I understand that services may be terminated at any time if information is found to be inaccurate or withheld.

Signature _____ **DATE:_____**