

Dr. Michael M. Judkins, Optometrist

Welcome to Our Office

Please fill out the information requested so that we may better serve you. Please print. Thank you

Name: _____ Date of Birth: ____/____/____
Last First Month Day Year

Address: _____
City State Zip

Social Security # ____-____-____ Patient's Sex: Male Female

Phone - Home: _____ Work: _____ Cell: _____ Text: Yes/No

Marital Status: _____ Occupation: _____ Employer: _____

Email: _____ Primary Care Physician: _____

<u>Race</u>	<u>Preferred Language</u>	<u>Ethnicity</u>	<u>Communication Preference</u>
<input type="checkbox"/> Caucasian	<input type="checkbox"/> English	<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> E-Mail
<input type="checkbox"/> Asian	<input type="checkbox"/> Spanish	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Postal
<input type="checkbox"/> Hispanic	<input type="checkbox"/> Other	<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> Telephone
<input type="checkbox"/> Native Hawaiian/other	<input type="checkbox"/> Decline	<input type="checkbox"/> Decline	<input type="checkbox"/> Text
<input type="checkbox"/> American Indian or Alaska Native			
<input type="checkbox"/> African American			
<input type="checkbox"/> Decline			

How did you find out about our office? Insurance Facebook Friends/family: _____

Medical and/or Vision Plan Information

The following information must be provided in order for us to submit your claim to your Medical and/or Vision provider. Thank you.

Insured's Information

Insured's Name: _____ Insured's Date of Birth: ____/____/____

Street Address: _____ SSN# ____-____-____

City, State, Zip: _____

Telephone Number: _____ Insured's Sex: Male Female

Medical Plan Name: _____ Medical ID Number: _____ Group Number: _____

Vision Plan Name: _____ Vision Plan ID Number: _____

Patients Relationship to Insured: Self Spouse Child Other _____