



1254 Litiz Pike • Lancaster, PA 17601-4340 • 717-397-4724 • Fax 717-397-6687

Eye Associates of Lancaster strives to provide our patients with the best possible care. The information requested is needed to help us serve you.

PLEASE RETURN FORMS TO EYE ASSOCIATES AS SOON AS POSSIBLE

Patient's Name : Mr Mrs
 Ms Miss _____
(first) (middle) (last)

Address: _____
(street) (apt) (city) (state) (zip)

Home Phone: () _____ Bus Phone: () _____

Date of Birth: _____ Cell Phone: () _____
(month / day / year)

Social Sec #: _____

Sex: Male Female Marital Status: Single Married Divorced Widowed

Is Patient employed? _____ Student/FT? _____ Student/PT? _____

Employer/School: _____

Employer/School Address: _____

Responsible person/address: (if patient is under 18 yrs old)

EMERGENCY CONTACT PERSON: _____ Relationship to Patient: _____

(Address)

(Phone)

Is Patient's condition related to:

Employment? Yes No

Auto Accident? Yes No

Other Accident? Yes No

Primary Care Physician

Name & Address: _____

How did you hear about us? Yellow Pages Newspaper Family/Friends Radio

Family Doctor Other _____

What is your Email address? _____

