

BETTNER VISION

9205 N. Union Blvd, Ste 110

719-282-0400

Patient Information (confidential)

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____

Cell: _____

Work: _____

Email: _____

DOB: _____

SSN: _____

Marital Status: married divorced single widow

Gender: F____ M____

Hobbies: _____

Employment status: P/T F/T Retired Unempl Student

Employer: _____

Occupation: _____

Emergency contact: _____

Phone: _____ relationship: _____

Referred by: _____

DO YOU HAVE VISION INSURANCE? Yes____ No____

VSP____ EYEMED____ SPECTERA____ DAVIS____ TRICARE____ OTHER____

Name of policy holder: _____

DOB: _____ SSN: _____

Relationship to patient: _____

DO YOU HAVE MEDICAL INSURANCE? Yes____ No____

Insurance carrier: _____ ID# _____

Name of Policy holder: _____ relationship to patient: _____