

# Eyesight Ophthalmic Services, P.A.

155 Borthwick Avenue, Suite 200 East

Portsmouth, NH 03801

(603) 436-1773

**\*\*PLEASE LIST ALL MEDICATIONS/VITAMINS/HERBALS AND THE DOSAGES,  
AS WELL AS ANY ALLERGIES, ON REVERSE.**

PATIENT INFORMATION										
NAME (Last, First, Middle initial)					SSN #		BIRTHDATE		LANGUAGE	SEX
LOCAL ADDRESS			CITY, STATE, ZIP			PRIMARY CARE PHYSICIAN		REFERRING PHYSICIAN		
HOME PHONE		DAY PHONE		SECONDARY HOME PHONE/CELL PHONE			EMAIL ADDRESS			
SECONDARY ADDRESS (If applicable)					CITY, STATE, ZIP					
MARITAL STATUS	STUDENT STATUS FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/>		SMOKER (Y/N) ?	VETERAN (Y/N) ?	EMERGENCY CONTACT NAME			CONTACT PHONE		
PRIMARY EMPLOYER					SECONDARY EMPLOYER					
ADDRESS					ADDRESS					
CITY, STATE, ZIP					CITY, STATE, ZIP					
WORK PHONE					WORK PHONE					
RESPONSIBLE PARTY INFORMATION (If different than above)										
NAME (Last, First, Middle initial)					SSN #		BIRTHDATE		LANGUAGE	SEX
LOCAL ADDRESS			CITY, STATE, ZIP			PRIMARY CARE PHYSICIAN		REFERRING PHYSICIAN		
HOME PHONE		DAY PHONE		SECONDARY HOME PHONE/CELL PHONE			EMAIL ADDRESS			
SECONDARY ADDRESS (If applicable)					CITY, STATE, ZIP					
MARITAL STATUS	STUDENT STATUS FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/>		SMOKER (Y/N) ?	VETERAN (Y/N) ?	EMERGENCY CONTACT NAME			CONTACT PHONE		
RELATIONSHIP TO PATIENT										
PRIMARY INSURANCE										
NAME OF INSURANCE COMPANY					POLICY #					
NAME OF SUBSCRIBER			DOB		GROUP #					
ADDRESS OF INSURANCE COMPANY					COPAY AMOUNT					
CITY, STATE, ZIP			PHONE		DEDUCTIBLE					
RELATIONSHIP TO PATIENT					EFFECTIVE DATE		EXPIRATION DATE			
SECONDARY INSURANCE (If applicable)										
NAME OF INSURANCE COMPANY					POLICY #					
NAME OF SUBSCRIBER			DOB		GROUP #					
ADDRESS OF INSURANCE COMPANY					COPAY AMOUNT					
CITY, STATE, ZIP			PHONE		DEDUCTIBLE					
RELATIONSHIP TO PATIENT					EFFECTIVE DATE		EXPIRATION DATE			

SIGNATURE OF PATIENT/GUARDIAN \_\_\_\_\_

DATE \_\_\_\_\_

# Welcome to Eyesight

\$25.00 off your first complete eyeglass purchase

TO: Our valued new patient  
FROM: The Optical Department



Excludes Mount Jim  
& Value Packages

