ILLINOIS eye CENTER
Your Vision Empowered

Register online at www.illinoiseyecenter.com
or
complete form (please print).

Acct. No._____

Patient's Name: _____ Sex: _____
Last First Middle

Address: _____
Street City State Zip Code

Home Phone: _____ Cell Ph. _____ Busn.Ph.: _____ Ext:_____

Date of Birth: _____ Social Security #:_____

Patient Occupation:_____ Employer:_____

Spouse's Name:_____Spouse Employer:_____

E-mail address:_____

How would you prefer to be contacted by our office?:

____Home Phone ____Cell Phone ____Work Phone ____E-mail ____U S Mail

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Emergency Contact (other than someone living with you) Phone #:_____

Name:_____ Relationship:_____

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Payment is expected on day of service. Person Responsible for payment (legal guardian or parent if patient is under 18 years old)

Relationship to patient (circle one) Self Parent Guardian Other_____

Name:_____ Employer:_____

Address: _____
Street City State Zip Code

Home Phone:_____ Work Phone:_____

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Vision Plan: Do you have Vision Insurance? ___No ___Yes ID#_____

(circle one): Eyemed VSP Humana VCP Proctor Pref/Forward 55 Other _____

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Primary Medical Insurance:_____Phone_____

Address:_____
Street City State ZipCode

Cardholder's Name:_____ Date of Birth:_____

ID #:_____ Group #:_____

Secondary Medical Insurance:_____Phone_____

Address:_____
Street City State ZipCode

Cardholder's Name:_____ Date of Birth:_____

ID #:_____ Group #:_____