



Dr. James L. Davis Jr., O.D.

Today's Date:

\_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_ Gender:  Male  Female  
Last First MI

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

City: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

Marital Status:  Married  Divorced  Single  Widow(er) Social Security Number: \_\_\_\_\_

Employment Status:  Full-Time  Part-Time  Unemployed  Retired  Full-Time Student  Other | \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

**PLEASE COMPLETE QUESTIONS 1, 2, 3 & 4 IN FULL.** If no vision or medical insurance information is given we will not be able to submit a claim or give any discount. If incomplete or inadequate insurance information is provided we will not be able to credit or reimburse your account for any discounts discovered after your purchase.  
*(Some exams can be submitted to Health Insurance with a medical diagnosis. Examples: Diabetes, Cataract, Glaucoma, Infection, etc.)*

1 Do you have Medicare?  Yes  No Medicare I.D. Number: \_\_\_\_\_

2 Do you have Health Insurance?  Yes  No

Insurance Company: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

Group #: \_\_\_\_\_ Is policy holder's address the same as patients?  Yes  No

Insured I.D.#: \_\_\_\_\_ Insured Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

3 Do you have Supplemental Health Insurance?  Yes  No

Insurance Company: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

Group #: \_\_\_\_\_ Is policy holder's address the same as patients?  Yes  No

Insured I.D.#: \_\_\_\_\_ Insured Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

4 Do you have Vision Insurance?  Yes  No

Insurance Company: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

Group #: \_\_\_\_\_ Is policy holder's address the same as patients?  Yes  No

Insured I.D.#: \_\_\_\_\_ Insured Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Person or persons we are allowed to discuss your eye care or account information with;

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

In case of emergency please call: \_\_\_\_\_ at (\_\_\_\_) \_\_\_\_\_

(Continued on back)