**CHERRY CREEK EYE PHYSICIANS AND SURGEONS, P.C.**
Stuart A. Lewis, MD FACS, Tammy Gray, OD & Rachel Lewis, OD

**Date**: _____

## PATIENT INFORMATION

Patient Name: _____ Referred By: _____

Age: _____ Date of Birth: _____ Sex: _____ SSN# _____

Address: _____
Street Apt City State ZIP

Home Phone Number: _____ Work Phone Number: _____

Mobile Phone Number: _____ Email: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

## Pharmacy Name, Phone Number, and City or Cross Street

_____

## INSURANCE INFORMATION

**Primary** Insurance: _____ **Subscriber's** Name: _____

Date of Birth: _____ **Subscriber's** SS# _____

**Secondary** Insurance (if applicable): _____

**Vision** Insurance Name (if applicable): _____

## INFORMATION FOR MINOR CHILDREN ONLY

Name of Person **Responsible** for Payment of Account: _____

Relationship to Patient: _____

Address of Responsible Party (**if different from above**):

_____
Street Apt City State Zip

Home Phone: _____ Work Phone: _____

## HIPAA Acknowledgement

Patient Name (Print): _____ Patient/Guardian Signature: _____

*(For a written copy of the HIPAA Privacy Policy, please request from front office staff)*