ECSC II -- Vision Quest
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4501 Joe Ramsey Blvd East, Suite 210 Greenville, TX 75401
Phone: 214-361-1443 – Fax 214-691-3299- www.visionquestdallas.com

PATIENT PROFILE

Patient's Name: ____ Sex: M / F
(First) (Initial) (Last)

Address: ______________________________ City: ____________________ State: ______ Zip: _______

Home Phone: (_____) __________________ Cell Phone: (_____) ______________________________

Date of Birth: _____/_____/_____ Patient's Social Security Number: ________--_______--_______

Email Address: ______________________________ Marital Status: Single / Married / Widow

Person to notify in case of an emergency: (Name) ____

Relation to patient: ___________________________________ Phone: (_____) ___________________

Pharmacy name: _____________________________________ **Phone**: (_____) ___________________

Place of Employment:

Employer: ____

Address: ____

City: ____ State: ___________

Zip: ________________ Phone: (_______) _________________________

Who may we thank for referring you?

❒ Doctor -- their name: ____

❒ Insurance ____

❒ Friend, relative, other -- their name: ____

❒ Internet -- what site: ____

❒ Other: ____

Please list all current and former doctors and their specialties, address and phone numbers. It may be necessary to obtain medical information from them.

DOCTOR	SPECIALTY	ADDRESS	PHONE

INSURANCE INFORMATION:

Patient's Full Name: ____

Responsible Party (if other than patient):

Name: ______________________________ Relation to Patient: ____________

Address: ______________________________

City: ____________________ State: _______ Zip: ________ DOB: ___/___/_____

Home Phone: (_____) ________________ Work Phone: (_____) ________________

Please check those items below that apply to you:

❒ **Medicare** -- Number: _________--_________--_________ Your Primary Insurance? **Yes No**

- Are you covered under Medicare HMO Policy? **Yes No**

If **Yes**, which HMO Plan ______________________________

❒ **Medicaid** -- Medicaid Number: ______________________________

❒ **Commercial Insurance Company** ❒ **HMO** ❒ **PPO**

Name: ______________________________

Address: ______________________________

City: ________________ State: _______

Phone: (____) __________ Zip: _________

Group or Policy Number: ________________

Identification #: ______________________

Policy Holder's name: ______________________

Policy Holder's Work History:

Employer: ______________________________

Address: ______________________________

City: ____________________ State: ______

Phone: (____) ____________ Zip: _______

Relation to Patient:

Policy holder's Social Security ##: ______--_____--_______ **Date of Birth:** ___/___/_____

Telephone number to verify coverage: (_____) ________________

Primary Care Physician (PCP): ______________________ Phone: (____) ____________

❒ **Commercial Insurance Company** ❒ **HMO** ❒ **PPO**

Name: ______________________________

Address: ______________________________

City: ________________ State: _______

Phone: (____) __________ Zip: _________

Group or Policy Number: ________________

Policy Holder's name: ______________________

Policy Holder's Work History:

Employer: ______________________________

Address: ______________________________

City: ____________________ State: ______

Phone: (____) ____________ Zip: _______

Relation to Patient: ________________

Policy holder's Social Security ##: ______--_____--_______ **Date of Birth:** ___/___/_____

Telephone number to verify coverage: (_____) ________________

Primary Care Physician (PCP): ______________________ Phone: (____) ____________

❒ **No Insurance -- (Circle one):** I will pay by: Cash, Check, MasterCard, Visa, Discover or American Express

I also certify and acknowledge that I have received a copy of the Notice of Privacy Practices Policy.

Signature: ______________________________ Date: ______________

VISION QUEST

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