Rebecca Sparks, OD
Sparks Eye Care LLC
307 W Highway 54, Ste 100
Andover, KS 67002
316-201-1837

Today's Date: _____

General Patient Information

Patient Name: _____
First Middle Last

How do you wished to be addressed? _____

Date of Birth: _____ Gender: M / F

Home Address: _____

_____

Marital Status: _____ Single _____ Married ____ Divorced ____ Widowed

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Place of Employment: _____

E-mail: _____

SSN: _____

Emergency contact: _____
Name/Relationship Phone

_____
Address (Indicate if different from patient address above)

I prefer to receive my appointment reminders by: _____
(cell phone call, text, e-mail, call)
*message charges may apply based on your plan

How did you hear about us? _____

Billing information (If different from patient)

Name of Insured/Responsible for Account: _____

Relationship to Patient: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Address (If different from patient): _____

_____

Insurance

Primary Insurance: _____ Policy Number: _____

Group Number: _____ Employer: _____

SSN and DOB of Policy Holder (If different from patient): _____
SSN DOB

Secondary Insurance: _____ Policy Number: _____

Group Number: _____ Employer: _____

SSN and DOB of Policy Holder (If different from patient): _____
SSN DOB

I hereby authorized the release of any medical information to process all claims, and request payment of any medical benefit to be paid to Sparks Eye Care, LLC.

_____
Signature of Patient/Guardian Relationship to Patient

_____
Date