

LINDY EYE CARE entry form:

Name: (Last, first) _____ **DOB** ____/____/____ **Gender:** M or F

Phone: (Home) _____ (Cell) _____ **Preferred:** H C

Email address: _____ **Soc Sec #:** _____

Home address: _____

New patients: How did you find out about our office? _____

If referred, who may we thank for the referral? _____

Insurance Information: (note: Medical insurance covers medical, but not refraction or contact lens fees)

PLEASE LEAVE YOUR INSURANCE CARDS OUT FOR RECEPTIONIST. THANK YOU

PRIMARY Medical Insurance: _____ **ID#:** _____

Policy holder name: _____ Policy holder DOB ____/____/____ Relationship to card holder _____

SECONDARY Medical Ins: _____ **ID#:** _____

Policy holder name: _____ Policy holder DOB ____/____/____ Relationship to card holder _____

OPTICAL Insurance: _____ Policy holder _____ Policy holder DOB ____/____/____

Policy holder ID or SS# _____ Relationship to policy holder _____

Please understand that all services must be paid for when received. Contact lens fees are separate from routine eye exam fees.

Please reply to our post-exam surveys, or contact us at: lindyeyecare@aol.com, or on our website: www.lindyeyecare.com.

Thank you for letting us serve you!

Former patients: Review carefully; if no changes from previous, please initial and date below:

_____/_____/_____/_____/_____

Lindy Eye Care – Dr. Mario J. Craig – 651 N. Wellwood Ave, Lindenhurst, NY 11757

Phone: 631-226-2020 – Fax: 631-226-7371 – www.lindyeyecare.com

[Email: Lindyeyes2020@gmail.com](mailto:Lindyeyes2020@gmail.com)