



Cutler Eye Care Associates, P.C.

James K. Cutler O.D.

GET-ACQUAINTED QUESTIONNAIRE

Date: \_\_\_\_\_

NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_

ZIP CODE: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ ALTERNATE PHONE: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

PLACE OF EMPLOYMENT: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

GUARANTOR (PERSON WHO CARRIES INSURANCE) \_\_\_\_\_

GUARNTOR ADDRESS: \_\_\_\_\_

PRIMARY MEDICAL INS: \_\_\_\_\_ SECONDARY MEDICAL INS: \_\_\_\_\_

PRIMARY VISION INS: \_\_\_\_\_ SECONDARY VISION INS: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ PHONE: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE? \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PARENT (IF MINOR)

\_\_\_\_\_  
DATE

This form is important for this office to have in order to maintain current and accurate records of our patient's demographic and insurance information. This will in turn ensure accuracy and efficiency in handling your care.