Dr. James K. Cutler
Specializing In Vision Care

GET-ACQUAINTED QUESTIONNAIRE

Date: ________

NAME:____ DOB:________

HOME ADDRESS:__________________________ CITY:____________ STATE:_____

ZIP CODE:_________HOME PHONE:______________ALTERNATE PHONE:________

EMAIL ADDRESS:____

PLACE OF EMPLOYMENT:____

OCCUPATION:____

MARITAL STATUS: ______________ SOCIAL SECURITY NUMBER:______________

GUARANTOR (PERSON WHO CARRIES INSURANCE) _________________________

GUARNTOR ADDRESS:____

PRIMARY MEDICAL INS:______________SECONDARY MEDICAL INS:___________

PRIMARY VISION INS:________________SECONDARY VISION INS:_____________

FORMER OPTOMETRIST:__________________________ LAST EXAM:___________

PRIMARY PHYSICIAN:__________________ PHONE:__________________________

ADDRESS:____

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.