Drs. Campbell Cunningham Taylor & Haun

EyeCare Optical
A Division of Drs. Campbell, Cunningham, Taylor & Haun

Last Name: First Name: MI:

Address: City: State: Zip:

Phone: Preferred ☒ ☐ (Home) ☐ (Cell)

Date of Birth: Social Security Number:

Email: Today's Date:

We encourage our patients to participate in their healthcare and communicate with our practice by utilizing our portal, myPatientVisit. Please select where you would like your registration link sent:

☐ Mobile Phone (Text Message) ☐ Email

Gender: ☐ Male ☐ Female Marital Status: ☐ Married ☐Single ☐Divorced ☐Widowed

Ethnic Group: ☐ Asian ☐ Black ☐ Caucasian/White ☐ Hispanic ☐ Other

Employer: Phone:

Spouse or *Guardian* Name: Phone:

Spouse or *Guardian* Date of Birth: Social Security Number:

Emergency Contact: Phone: Relationship:

Referring Physician: Phone:

Primary Care Doctor: Phone:

Pharmacy Name: Phone:

Do you have a Living Will? ☐ Yes ☐ No Power of Attorney? ☐ Yes ☐ No

Insurance Information: *(You will need to bring your insurance cards and photo ID to your appointment)*

Primary Insurance: Policy ID:

Secondary Insurance: Policy ID:

Primary Insurance Subscriber's Name: DOB:

Secondary Insurance Subscriber's Name: DOB:

How Did You Learn About Our Practice?

☐ Friend ☐ Relative ☐ Internet ☐ Shopper ☐ Word of Mouth ☐ Insurance ☐ Doctor

☐ Walk-In ☐ TV ☐ Radio ☐ Mailer ☐ Current Patient ☐ Building Sign

Other: