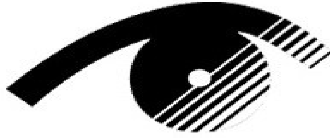

SPRINGFIELD EYE ASSOCIATES, INC.

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BRIAN K. BREDVIK, M.D. MATTHEW C. KIDD, O.D.

PLEASE PRINT Please fill in all Information below and have all insurance and Identification Cards ready to be scanned.

TODAY'S DATE: _________________________ PRIMARY CARE PHYSICIAN: _______________________________

LAST NAME______________________________FIRST_________________________M.I.______

PREFERRED NAME _____________________________

STREET ADDRESS________________________ CITY___________________ STATE______ ZIP______________

HOME PHONE: ______________________ CELL PHONE: ________________________ WORK PHONE: _____________________

IS IT OK TO LEAVE A DETAILED MESSAGE? YES NO

DATE OF BIRTH______________________________ SEX AT BIRTH: M F

GENDER INDENTITY_______________________________ PREFERRED PRONOUN(S):_________________________

EMAIL ADDRESS: __________________________________ SOCIAL SECURITY NUMBER: _______________________________

MARITAL STATUS: Single Married Widow Divorced

RACE: ______________________ETHNICITY: _____________________PRIMARY LANGUAGE: ____________________________

CONTACT PERSON IN CASE OF EMERGENCY:NAME_____________________________PHONE___________________________
RELATIONSHIP_________________________

PREFERRED PHARMACY & LOCATION:

NAME OF PERSON RESPONSIBLE FOR INSURANCE OR PAYMENT

PRIMARY INSURANCE ________________________________ POLICY NUMBER: ________________________ DOB: _________

POLICY HOLDER______________________________________RELATIONSHIP TO PATIENT: ____________________________

ADDRESS IF DIFFERENT FROM PATIENT: ____

SECONDARY INSURANCE _____________________________ POLICY NUMBER: ________________________ DOB: _________

POLICY HOLDER: _____________________________________RELATIONSHIP TO PATIENT: ____________________________

ADDRESS IF DIFFERENT FROM PATIENT: ____

WORKMAN'S COMP (INJURY DATE): ______________________________ REPORTED YES NO

EMPLOYER: ____ OCCUPATION____________________________________

EMPLOYER ADDRESS: ____PHONE: _____________________________