John Duvall, M.D.
Cynthia Tarkanian, M.D.

ARVADA EYE ASSOCIATES

Annie Chang, M.D.
Malcolm Tarkanian, M.D.

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Sex: ❑ M ❑ F	Marital status Single / Married / Widowed

Birth date: / /	Age:	Home phone no.: ( )	Cell phone no.: ( )

Street address:	Apt./Unit no.:

City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Parents Name (if patient is a minor)	Phone no.:

Spouse's Name:	Birth Date: / /	Employer:

Referred By:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

VISION INSURANCE: ❑ Yes ❑ No Insurance Name: Social Security/ID #

PRIMARY MEDICAL INSURANCE:

Subscriber's name:	Subscriber's SSN.:	Birth date: / /	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

SECONDARY MEDICAL INSURANCE:	Subscriber's Name:	Birth date: / /	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )