CAROLINA EYECARE PHYSICIANS, LLC
Excellence in Ophthalmic Care

John G.P. Boatwright, M.D. Paul M. Herring, M.D. Thomas J.Newland, M.D. Robert G. Reuther, M.D. R. Griffin Brame, M.D. H. Paul Cooler, M.D. Paul M. Grant, M.D.
Jeffrey K. Richards, M.D. Sidney M. Seltzer, M.D. Kerry D. Solomon, M.D. Jeffrey Hood, O.D.
843-881-3937 (EYES)
"Excellence in Ophthalmic Care"
"Convenient Locations throughout the Low country to serve you"

West Ashley	**North Charleston**	**Moncks Corner**	**Walterboro**	**Summerville**	**Mt Pleasant**
2060 Charlie Hall Blvd	2861 Tricom St	730 Stony Landing Rd	459 Spruce St	320-A Midland Pkwy	1280 Johnnie Dodds Blvd.

Welcome to our practice: Please fill out the following information completely:

1. Patient Information:

Social Security No: _____ E-Mail Address: _____

Name: (Last) _____ (First) _____ (M.I.) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Sex: M F Marital Status: S M D W

Employed: No _____ Full Time _____ Part Time _____ Retired _____ Business Phone: _____

Name of Employment or School: _____

2. Guarantor Information:

Same as Above: ☐ Yes **If patient is a minor please fill out.**

Social Security No: _____ E-Mail Address: _____

Name: (Last) _____ (First) _____ (M.I.) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Sex: M F Marital Status: S M D W

Employed: No _____ Full Time _____ Part Time _____ Retired _____ Business Phone: _____

Name of Employment or School: _____

3. Insurance Information:

Primary Insurance: _____ Policy #: _____

Insured's Name: _____ DOB: _____ Insured's SS# _____

Insured's Employment: _____ Work Phone: _____

Secondary Insurance: _____ Policy #: _____

Insured's Name: _____ DOB: _____ Insured's SS# _____

Insured's Employment: _____ Work Phone: _____

4. Appointment Information:

Family Doctor: _____ Referring Doctor Name: _____

Who recommended you to our practice: _____

List any family members who are patients: _____

_____

Emergency Contact:

Name: _____ Relationship: _____ Phone No: _____