Chapel Hill Eyecare
OD, PLLC Healthy Eyes for a Lifetime™

235 S. Elliott Rd
Chapel Hill, NC 27514
Dr. Scott Sikes & Dr. Laurel Gropper

Name _____ **Date** _____ **DOB** _____

Address _____ **City** _____

State _____ **Zip** _____ **Occupation** _____

Preferred Method of Contact: PHONE EMAIL TEXT (Circle One)

- Home Phone _____
- Cell Phone _____
- Email _____

May we send you appointment reminders via:

- Text Y N
- Email Y N

Race _____

Ethnicity

- Hispanic
- Non-Hispanic

Preferred Language

_____

Marital Status

- Single
- Married
- Other

Gender

- Male
- Female

Emergency Contact

_____

Relation to Patient

_____

Phone Number

_____

How did you hear about our office?

- Our Website (www.chapelhilleyecare.com)
- Social Media (Facebook / Twitter / Instagram)
- Search Engine _____
- Doctor _____
- Friend / Relative _____
- Other _____

Primary Insurance

- **BCBS**
- **Medicare**
- **United Healthcare**
- **Superior Vision**
- **Community Eyecare**
- **Other** _____

Please Present Your Insurance Card(s) to the Front Desk

I authorize Chapel Hill Eyecare to file insurance on my behalf for all services rendered. I further understand that although insurance will be filed when applicable, I am ultimately responsible for the timely payment of this account.

Signature _____ **Date** _____