



# Thames Eye Group

*Your Eyes Are Our Specialty!*

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## Patient Information Form

**Please Complete in Full**

PATIENT'S LAST NAME		FIRST NAME		MIDDLE INITIAL	HOME PHONE NUMBER
HOME ADDRESS	STREET ADDRESS			APARTMENT NUMBER	
	CITY		STATE	ZIP CODE	
DATE OF BIRTH		SOCIAL SECURITY NUMBER	MARITAL STATUS		SEX
			<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D		<input type="checkbox"/> M <input type="checkbox"/> F
EMPLOYER		EMPLOYER ADDRESS			IS THIS WORK-RELATED?
					<input type="checkbox"/> Y <input type="checkbox"/> N
SPOUSE/PARENT NAME		SPOUSE/PARENT EMPLOYER			
SPOUSE/PARENT WORK PHONE		SPOUSE/PARENT SOCIAL SECURITY NUMBER			
SPOUSE/PARENT ADDRESS		SPOUSE/PARENT DATE OF BIRTH			
PRIMARY CARE PHYSICIAN		PHYSICIAN PHONE NUMBER			

**PLEASE PRESENT INSURANCE CARDS TO RECEPTIONIST**

- Y    N   You may contact me at work. Telephone number \_\_\_\_\_  
 Y    N   You may leave a message regarding my appointment on my answering machine  
 Y    N   You may leave a message regarding my appointment with \_\_\_\_\_

**PLEASE COMPLETE THE SECOND PAGE OF THIS FORM**