Patient Information

Check Us Out on FACEBOOK

Last Name	First Name	MI	DOB	Today's Date

Mailing Address	City County	State	ZIP Code

Home phone # Cell phone #	Work Phone (Ext)	Preferred method for your next appointment reminder ☐Text ☐E-mail ☐Phone Call	Social Security # Marital Status ☐Single ☐Married ☐Divorced

Email: **Secondary Address & Phone Number (if applicable)**

Emergency Contact:

Phone #

Race ☐Black or African American ☐American Indian or Alaska Native ☐Asian ☐White ☐Native Hawaiian or Other Pacific Islands ☐Patient Declined

Ethnicity ☐Not Hispanic or Latino ☐Hispanic or Latino ☐Chinese ☐Filipino ☐Japanese ☐Multi-Racial ☐Other

How Did You Hear About Our Practice?

☐Facebook ☐Website ☐Newspaper ☐Radio ☐Yellow Pages
☐Patient of Eye Care ☐School ☐Prior Patient ☐Physician Name: _____

Insurance Information

Primary Insurance Name		Secondary Insurance Name	

Claims Address	Claims Address
City, State, ZIP	**City, State, ZIP**

Subscriber's Name	Subscriber DOB	Subscriber's Name	Subscriber DOB
Subscriber's ID No.	**Group No.**	**Subscriber's ID No.**	**Group No.**
Patient's Relation to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other		**Patient's Relation to Subscriber** ☐ Self ☐ Spouse ☐ Child ☐ Other	

Please provide the following information so we may improve patient care

Primary Care Physician:
Address:
Phone Number:

Drug Store/Pharmacy:
Address:
Phone Number:

Patient Employment: ☐Employed ☐Retired ☐Unemployed ☐Other

Employer Name: **Address:**

Occupation: **Phone:**

Patient Guarantor

Guarantor: ☐Self

Name: **Address:** **City/State/Zip**

Date of birth: **SSN:** **Phone #**

I understand that payment for any unpaid balances will be my responsibility.

Signature/Parent/Guardian_____ **Date**_____

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PRINT