Patient Information

Name:_______________________________________ Nickname:___________________**Age**:______**Date of Birth**:_____/____/______

Address:____**City**:___________________________**Zip Code**: ____________________

Home Phone:______________________________**Work Phone**:________________________**Cell**: ______________________________

Email Address:______________________________________**How did you hear about our office?** ______________________________

Social Security #:___________________**Emergency Contact Name & Phone #:** ____

IF UNDER 18, PARENT/GUARDIAN TO CONTACT: ____

Employer:____**Occupation**: ____

Marital Status: (please circle) Single—Married—Divorced—Widowed **Gender**: (Please Circle) Male or Female

Primary Care Physician:_________________________________**Referring /Specialty Dr**.___________________________________

Preferred Pharmacy:____________________________________**Location** (street & city) _____________________________________

Race: □ American Indian or Alaska Native □ Asian □ Black or African American

□ Native Hawaiian or Other Pacific Islander □ White

Ethnicity: □ Hispanic □ Not Hispanic

Preferred Language: □ English □ French □ Italian □ Japanese

□ Russian □ Spanish □ Portuguese

May We Provide/Retrieve Updated Information From Your Family Doctor? Yes / No

May We Provide/Retrieve Updated Information From Your Pharmacy? Yes / No

May we leave a message at your home with other residents? Yes / No

May we leave a message on your Answering Machine / Voice Mail / Cell Phone? Yes / No

May we communicate with you via E-Mail for special events and patient education videos? Yes / No

Whom may we talk to about your medical/billing concerns? Any Family/ Other

Name and Relationship of this person to you?

May we communicate with you via Cell Phone? Yes / No

What phone number do you prefer us to call to leave a message? (Circle All That You Prefer) Home Phone Work Phone Cell Phone

Signature:____**Date**: ________________________________

Signature if other than patient:____**Date**: ________________________________

Relationship to patient: ____

Insurance Information

Primary Vison Insurance:

Insurance Company: ____

Insurance ID number: ____

Name of policy holder: ____

Relationship: ____

SSN of Policy Holder: ___-__-____

DOB of Policy Holder: ______

Secondary Vision Insurance:

Insurance Company: ____

Insurance ID number: ____

Name of policy holder: ____

Relationship: ____

SSN of Policy Holder: ___-__-____

DOB of Policy Holder: ______

Primary Medical Insurance:

Insurance Company: ____

Insurance ID number: ____

Name of policy holder: ____

Relationship: ____

SSN of Policy Holder: ___-__-____

DOB of Policy Holder: ______

Secondary Medical Insurance

Insurance Company: ____

Insurance ID number: ____

Name of policy holder: ____

Relationship: ____

SSN of Policy Holder: ___-__-____

DOB of Policy Holder: ______