



PATIENT INFORMATION

(Please print clearly)

DATE \_\_\_\_\_

Name \_\_\_\_\_ Phone # (Home) \_\_\_\_\_
LAST FIRST MIDDLE

Mailing Address \_\_\_\_\_ Phone # (Work) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone # (Cell) \_\_\_\_\_

Email \_\_\_\_\_

Contact Preference: [ ] Home phone [ ] Work phone [ ] Cell phone [ ] Email

Sex: [ ] M [ ] F Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_ [ ] Single [ ] Married [ ] Other \_\_\_\_\_

SS# \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Name of Spouse or Guardian \_\_\_\_\_

Person responsible for account \_\_\_\_\_ Emergency Contact Name \_\_\_\_\_

Phone # \_\_\_\_\_ Relationship to Emergency Contact \_\_\_\_\_

Release Medical Information [ ] Yes [ ] No

Name of your Pharmacy \_\_\_\_\_ Phone # \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Last visit (date) \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Phone # \_\_\_\_\_

Do you have another Eye Doctor? [ ] Yes [ ] No Did they ask you to come see us? [ ] Yes [ ] No

Eye Doctor's Name/Address/Phone \_\_\_\_\_

Date of last exam \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Do you wear: [ ] Glasses [ ] Contact lenses

Ethnicity: [ ] Hispanic/Latino [ ] Not Hispanic/Latino [ ] Declined to specify

Race: [ ] American Indian or Alaska Native [ ] Asian [ ] Black or African American
[ ] Native Hawaiian or Other Pacific Islander [ ] White [ ] Declined to specify

Language: \_ English \_ Spanish \_ Vietnamese \_ Mandarin \_ German \_ French \_ Hindi \_ Korean
\_ Tagalog \_ Sign Language or other Auxiliary Aid/Service \_ Decline to specify \_ Other

HEALTH INSURANCE COVERAGE

PLEASE INCLUDE ANY LETTERS WITH ID#. COPY OF INSURANCE CARD WILL BE REQUIRED

Primary Carrier \_\_\_\_\_ ID# \_\_\_\_\_ Grp# \_\_\_\_\_

Subscriber: [ ] Self [ ] Spouse [ ] Parent [ ] Subscriber Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Secondary Carrier \_\_\_\_\_ ID# \_\_\_\_\_ Grp# \_\_\_\_\_

Subscriber: [ ] Self [ ] Spouse [ ] Parent [ ] Subscriber Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

IF THE NAME OF THE INSURANCE POLICYHOLDER IS OTHER THAN THE PATIENT, PLEASE COMPLETE

Name of Policyholder \_\_\_\_\_

Address of policyholder \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone# (Policyholder) \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Employer of Policyholder \_\_\_\_\_