Regional Eye

PATIENT INFORMATION

Today's Date: _____

Patient Name: _____
First *Middle* *Last*

Address: _____
Street *City* *State* *Zip*

Date of Birth: _____ Age: _____ Last 4 of SS#: _____ ☐ MALE ☐ FEMALE

Preferred Phone: (_____) _____ ☐ Home ☐ Cell Secondary Phone: (_____) _____ ☐ Home ☐ Cell

Email: _____

☐ Check here if you ***DO NOT*** consent to receiving email/text messages, including appointment reminder messages

I authorize the practice to disclose or provide Protected Health Information to me as described below. I understand that it is my responsibility to notify the practice of any change in this manner of communication. This authorization is in effect until a written notification of revocation is received:

☐ Preferred Phone ☐ Secondary Phone ☐ Email listed above ☐ Mailing Address listed above

Primary Care Physician Name: _____ Address: _____

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ African American/Black
☐ White ☐ Native Hawaiian/Other Pacific Islander

EMERGENCY CONTACT

Name: _____ Relation: _____ Phone: _____

PREFERRED PHARMACY

Pharmacy: _____ Address: _____

RESPONSIBLE PARTY*

Name: _____ Relation: _____ Phone: _____

**Only complete this section if the patient is NOT the responsible party*

Address: _____
Street *City* *State* *Zip*

HOW DID YOU FIND US?

☐ Doctor: _____ ☐ Insurance Referral

☐ Internet/Online ☐ Friend/Family ☐ Social Media ☐ Advertisement/Other

MEDICAL INSURANCE

PRIMARY Insurance Co.: _____ Member ID: _____ Group/Policy No.: _____

Policy Holder Name/DOB: _____ Relation to Patient: _____

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Policy Holder Name/DOB: _____ Relation to Patient: _____

My signature below indicates the above information is correct and accurate to the best of my knowledge.

Name: _____ **Signature:** _____ **Date:** _____