ASSOCIATED EYE CARE PATIENT INFORMATION SHEET

PERSONAL INFORMATION (PLEASE PRINT)

Name: ____
First Middle Last Suffix

Date of Birth: ________________ Age:___________ M/F: ____________ Social Security #: ______________________________

Address: ____
Street Apt # City State Zip code

Phone #'s - Home: __________________________ Cell: ___________________________ Work: __________________________

Email Address: ____

Occupation: ______________________ Employer: _______________________________ Work #: ________________________

Preferred Language: ______________________ Race: ____________________ - Ethnicity: ____ Hispanic ____ Non-Hispanic

Marital Status: ___ Single ___ Married ___ Widowed ___ Divorced - Student Status: ____ Full Time ____ Part Time

Spouse's Name: _____________________________________ Date of Birth: ______________ SSN: ________________________

Spouse's Employer: ________________________________ Work #: ____________________ Cell # ________________________

Primary Care Physician: ____ Phone #: ________________________

Pharmacy: ____ Phone #: ________________________

PRIMARY MEDICAL INSURANCE: _________________________ Policy Holder: _____________________________________

Relation to Patient: ______________________ Date of Birth: ___________________ SSN: _____________________________

SECONDARY MEDICAL INSURANCE: _______________________ Policy Holder: _____________________________________

Relation to Patient: ______________________ Date of Birth: ___________________ SSN: _____________________________

VISION INSURANCE: ____________________________________ Policy Holder: _____________________________________

Relation to Patient: ______________________ Date of Birth: ___________________ SSN: _____________________________

Complete if you are under 18 years old or a student:

Father's Name: ____________________________________ DOB: _______________ Employer: ___________________________

Address: ____ Phone #: ________________________

Mother's Name: ___________________________________ DOB: _______________ Employer: ___________________________

Address: ____ Phone #: ________________________

Are you personally responsible for your fees? ____ Yes ____ No If not, who do we send the bills to?

Name: ____ Relation: ___________________ SSN#: ______________________

Address: ____
Street Apt # City State Zip code

Who should we notify in case of an emergency? (nearest relative or friend)

Name: ____ Relation: ____________________ Home #: ____________________

Address: ____ Cell #: ______________________

X____ __________________________

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY IF MINOR **TODAY'S DATE**