ASSOCIATED EYE CARE, INC.

PATIENT INFORMATION (PLEASE PRINT)

Name: _____ Gender at Birth_____
First Middle Last Suffix

Date of Birth: _____ Age:_____ Social Security #: _____

Address: _____
Street Apt/Lot # City State Zip code

Phone #'s - Home: _____ Cell: _____

Email Address: _____ Pharmacy _____

Occupation: _____ Employer: _____ Work #: _____

Primary Care Physician: _____ Phone #: _____

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 # _____

Who should we notify in case of an emergency? (If different from your spouse)

Name: _____ Relation: _____ Phone #: _____

INSURANCE INFORMATION:

NAME OF PRIMARY MEDICAL INSURANCE: _____ Policy Holder Name: _____

Relation to Patient: _____ Date of Birth: _____ SSN: _____

NAME OF SECONDARY MEDICAL INSURANCE: _____ Policy Holder Name: _____

Relation to Patient: _____ Date of Birth: _____ SSN: _____

NAME OF VISION INSURANCE: _____ Policy Holder Name**:** _____

Relation to Patient: _____ Date of Birth: _____ SSN: _____

ONLY COMPLETE IF PATIENT IS UNDER 18 YEARS OLD:

WHO BROUGHT PATIENT IN TODAY?

Name: _____ Phone #: _____ Relation: _____

WHO IS RESPONSILBE FOR YOUR FEES?

Name: _____ Date of Birth: _____ SSN#: _____

Address: _____

Relation: _____ Home #: _____ Cell #: _____

X_____ _____

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