Patient Information

Date: _____

Dr Int: _____

Patient Name: _____ **Date of Birth:** ___/___/_____

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

Home Phone #: _____ **Cell Phone #:** _____ **SSN:** _____-___-_____

Email: _____ **Occupation:** _____ **Sex:** _____

Preferred Contact: ☐ Home Phone ☐ Cell Phone **Marital Status:** _____

Race:

☐ Native American/Alaskan Native

☐ White/Caucasian

☐ African American

☐ Asian/Pacific Islander

☐ Other: _____

Ethnicity:

☐ Hispanic

☐ non-Hispanic

Language:

☐ English

☐ Spanish

☐ Other: _____

Reason for Visit: _____ **Last Eye Exam:** _____

Preferred Pharmacy: _____

Emergency Contact

Name: _____ **Phone #:** _____

Relationship to Patient: _____

Insurance

Primary Insurance: _____ **Policy #:** _____

Primary Insured: _____ **Date of Birth:** _____

Secondary Insurance: _____ **Policy #:** _____

Primary Insured: _____ **Date of Birth:** _____

Vision Insurance: _____ **Policy #:** _____

Primary Inured: _____ **Date of Birth:** _____

Personal History

Tobacco Use: Y / N **Alcohol Use:** Y / N **Pregnant/Nurs ng:** Y / N

Allergies to Meds: Y / N **If yes, please list:** _____

Height: _____ **Weight:** _____ **Primary Care Provider:** _____

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Vinita Family EyeCare's Notice of Privacy Practices.

Patient name _____

Signature_____ Date_____

My private health information may be released to:

_____

Name relationship phone number

_____

Name relationship phone number

_____

Name relationship phone number