PATIENT INFORMATION

DEMOGRAPHICS

NAME LAST FIRST MI						DATE
STREET ADDRESS						SS#
CITY		STATE				SPECIAL NEEDS ☐ WHEEL CHAIR ☐ HEARING IMPAIRED ☐ OTHER _____
COUNTY	ZIP CODE	LANGUAGE	BIRTHDATE		AGE	RACE / SEX
HOME / CELL PHONE ( ) -	WORK PHONE ( ) -		MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED			
EMPLOYER NAME / ADDRESS			EMAIL ADDRESS			
SPOUSE			SPOUSE'S WORK PHONE ( ) -			
EMERGENCY CONTACT			EMERGENCY PHONE ( ) -			

BILLING

GUARANTOR (FINANCIALLY RESPONSIBLE PERSON) NAME		RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER	
STREET ADDRESS		PHONE ( ) -	
CITY		STATE	ZIP CODE
PRIMARY INSURANCE	POLICY HOLDER	POLICY ID #	INSURED'S DOB
SECONDARY INSURANCE	POLICY HOLDER	POLICY ID #	INSURED'S DOB
SEND WORKER'S COMPENSATION TO	AUTHORIZED BY / POSITION	DATE OF INCIDENT	

REFERRAL

WHO REFERRED YOU TO OUR PRACTICE? NAME	☐ FRIEND / FAMILY ☐ PROLOGUE ☐ NEWSPAPER _____ ☐ PATIENT ☐ SIGN ☐ RADIO _____ ☐ YELLOW PAGES ☐ OTHER _____ ☐ MD / DO _____ ☐ OPTOMETRIST _____		
FAMILY OPTOMETRIST NAME			
PHONE ( ) -			
STREET ADDRESS	CITY	STATE	ZIP CODE
PRIMARY CARE DOCTOR **NAME**	**PHONE** **( ) -**		
STREET ADDRESS	**CITY**	**STATE**	**ZIP CODE**