

**Patient Information Form**  
**(Please Print)**

Patient Name:		Age:	Date of Birth:
Email:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Home Phone:	Cell Phone:		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Address:			
City:	State:	Zip:	
Check One: <input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian/Native Hawaiian/Pacific Islander <input type="checkbox"/> American Indian/Eskimo/Aleut <input type="checkbox"/> Other _____			
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____			
Social Security #:		Driver's License #:	
Employer:	Occupation:		Work Phone:
Family Physician:		Physician Phone:	
Spouse/Parent Name:		Spouse/Parent Birthdate:	
Spouse/Parent Phone:		Spouse/Parent Employer:	
Emergency Contact:		Phone:	
Referral Information: Doctor Name: _____ Office Phone: _____ Specialty: _____			

I authorize the Physician and Staff to perform those tasks necessary for medical care. I understand I may be given a return appointment to follow up on my ocular condition. I will not hold the Physician and/or staff responsible for any resulting consequences due to my failure to keep these appointments.

I certify that the above information is correct, and I understand that I am responsible for any co-payments, deductibles, or non-covered items at the time services are rendered. I authorize the Physician to release all information necessary to my insurance company to secure the payment of benefits.

Please check your communication preference:  Email     Cell Phone     Home phone     Text

No show policy received  Yes     No

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_