PATIENT INFORMATION SHEET

Primary EyeCare Associates
For a Lifetime of Healthy Vision

Date: ____________________

Patient Full Legal Name: ____

Male: _______ **Female:** _______

Date of Birth: ______________________ **Social Security # :** ____________________________

Address: ____

City/State: ____ **Zip Code:** ______________

Home Phone: _________________________________

Cell Phone: _________________________________

E-Mail: ____________________________________

Work Phone: ________________________________

Communication Preference:

☐ Phone

☐ Text

☐ Email

Employer: ____________________________________ **Occupation:** ____________________

Marital Status: Single ______ Married _______ Divorced _______ Widowed _______

Emergency Contact Not Living With You (Name and Phone #) _________________________
____

Spouse Information (if applicable):
Full Legal Name: ____
Employer Name: ____

Vision Ins. Type: ________________________ **Member Name:** ___________________________

Member DOB:___________________________ **Member SS #:** ___________________________

Family Physician and/or Specialist: ____

I understand and agree that (regardless on my insurance status), I am ultimately responsible for the balance of my account for any professional services or materials rendered. I certify this information is true and correct to the best of my knowledge. I will notify the office of any changes in my status of the above information.

Signature: ____ Date: _______________________