Save Print Form Clear Form

EYE MD MONTEREY

Today's Date:

PATIENT INFORMATION

First Name **Middle Name** **Last Name** **Preferred Name**

Home Address **Apt.** **City** **State** **Zip Code**

Social Security Number **Date of Birth** **Gender** ◯ Female ◯ Male

Marital Status ◯ Single ◯ Married ◯ Other

Home Phone **Cell Phone** **Other Phone** ◯ Pager ◯ Fax

Preferred Contact ◯ Home ◯ Work ◯ Cell ◯ Email ◯ Text **Email Address**

Who may we share your health information with? Name Relationship

Is it OK to call you and leave a message about your eye health including test results? ◯ Yes ◯ No **May we text you to confirm your appointment?** ◯ Yes ◯ No

Is it OK to call you at work? ◯ Yes ◯ No

Emergency Contact Information Relationship to Patient First Name Last Name

Home Phone Work Phone Cell Phone

Employment Status ◯ Full Time ◯ Full Time Student ◯ Active Duty ◯ Child ◯ Other ◯ Part Time ◯ Part Time Student ◯ Disabled ◯ Retired ◯ Unemployed

Occupation **Employer** **Employer Phone**

Race (optional) ◯ White ◯ African-American ◯ Asian ◯ American Indian / Alaska Native ◯ Native Hawaiian / Other Pacific Islander

Ethnicity ◯ Hispanic ◯ Non-Hispanic **Language**

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician **Referring Physician**

How did you hear about us? ◯ Physician ◯ Family Member ◯ Magazine ◯ Website ◯ DMV Ad ◯ Insurance ◯ Friend ◯ News Paper ◯ Yelp ◯ Military Guide

INSURANCE INFORMATION

Primary Insurance **ID#** **Group#**

Relationship to the sponsor Sponsor (if other than patient) DOB SS#

◯ Self ◯ Child ◯ Spouse ◯ Other

Secondary Insurance **ID#** **Group#**

Relationship to the sponsor Sponsor (if other than patient) DOB SS#

◯ Self ◯ Child ◯ Spouse ◯ Other

Vision Insurance **ID#** **Group#**

Relationship to the sponsor Sponsor (if other than patient) DOB SS#

◯ Self ◯ Child ◯ Spouse ◯ Other

PHARMACY INFORMATION

Preferred Pharmacy **Phone Number**

Street City State Zip Code

Signature of Patient / Guardian **Date**

Save Print Form Clear Form