

# PATIENT INFORMATION

## PERSONAL INFORMATION:

PATIENT'S NAME: \_\_\_\_\_  
Last First Middle Initial

AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ M/F: \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_ SSN #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
Street City State Zip

PHONE: HOME: ( ) \_\_\_\_\_ WORK: ( ) \_\_\_\_\_ CELL: ( ) \_\_\_\_\_

NAME OF PERSON TO CONTACT IN EMERGENCY: \_\_\_\_\_ PHONE: ( ) \_\_\_\_\_

OCCUPATION OR STUDENT'S GRADE: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_ PHONE: ( ) \_\_\_\_\_

PRIMARY CARE PHYSICIAN (PCP): \_\_\_\_\_ PCP PHONE #: \_\_\_\_\_

REFERRED BY:

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> DOCTOR: _____          | <input type="checkbox"/> NEWSPAPER AD |
| <input type="checkbox"/> FRIEND/RELATIVE: _____ | <input type="checkbox"/> YELLOW PAGES |
| <input type="checkbox"/> OTHER: _____           | <input type="checkbox"/> SELF         |

## PRIMARY INSURANCE INFORMATION:

PRIMARY INSURANCE: \_\_\_\_\_ ID #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_ SUBSCRIBER DOB: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

SUBSCRIBER'S EMPLOYER'S NAME: \_\_\_\_\_ SUBSCRIBER'S SSN: \_\_\_\_\_

## SECONDARY INSURANCE INFORMATION:

SECONDARY INSURANCE: \_\_\_\_\_ ID#: \_\_\_\_\_ GROUP #: \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_ SUBSCRIBER DOB: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

SUBSCRIBER'S EMPLOYER'S NAME: \_\_\_\_\_ SUBSCRIBER'S SSN: \_\_\_\_\_

## HIPAA NOTICE OF PRIVACY PRACTICES RECEIPT:

I acknowledge that I was provided with the Notice of Privacy Practices of the Medical Practice for Wise Family Eye Center.

\_\_\_\_\_  
SIGNATURE (Patient or Parent if minor) PRINT NAME DATE

If patient is a minor:  
Parent's Address: \_\_\_\_\_ Parent's SSN: \_\_\_\_\_ Parent's DOB: \_\_\_\_\_