Green Eye Center

Patient #________________

PATIENT INFORMATION

First Name______________________MI_____Last Name______________________

Address______________________City____________________State_____Zip_________

Please select the primary phone number

☐ Home Phone #____________________ ☐ Cell Phone #____________________

How do you want to receive appointment reminders? ☐ Call ☐ Text ☐ Email

E-mail Address____

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Date of Birth____________________Age__________S.S.#____________________

Race ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ *Declined*

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ *Declined*

Employer's Name______________________________Phone#________________

Employer's Address________________________City__________State_____Zip________

Emergency Contact____________________Phone#______________Relationship________

Primary Care Physician's Name__________________________Phone#________________

IF UNDER 18 YEARS OLD

Father's Name______________________DOB__________S.S.#________________

Mother's Name______________________DOB__________S.S.#________________

RESPONSIBLE PARTY

Responsible Party's Name______________________DOB________S.S.#______________

Primary Phone#______________________Relationship to Patient________________

Address______________________City____________________State_____Zip_________

INSURANCE INFORMATION

Primary Insurance Company____

Policy Holder's Name______________________DOB__________S.S.#______________

Vision Coverage? ☐ Yes ☐ No Name of Vision Ins Co______________________________

Employer________________________________Phone#______________________

Secondary Insurance Company____

Policy Holder's Name______________________DOB__________S.S.#______________

Vision Coverage? ☐ Yes ☐ No Name of Vision Ins Co______________________________

Employer________________________________Phone#______________________

X____Date____________________

Signature of patient or parent/guardian if minor