NEW VISION EYE CENTER PATIENT INFORMATION SHEET

DEMOGRAPHICS

Patient Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Street Address (if different from mailing): _____

Primary Phone: _____ Cell Phone: _____

Patient Employer: _____ Employer Phone: _____

Email Address: _____

Marital Status: _____ Sex: Ⓜ Ⓕ Date of Birth: ___/___/___

Social Security Number: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Number: _____

How would you like us to contact you? ◯ Phone ◯ Text ◯ Email

The information below is required for Electronic Medical Records:

Pharmacy Name & Location: _____

Preferred Language: _____

Ethnicity: ◯ Non Hispanic or Latino ◯ Hispanic or Latino

Race: ◯ Asian ◯ Black | African American ◯ White ◯ Other

◯ American Indian or Alaska Native ◯ Native Hawaiian or Pacific Islander

Which Doctor are you here to see?:

◯ O'Brien ◯ Tate ◯ Reinauer

INSURANCE INFORMATION

Primary Insurance: _____ Secondary Insurance: _____

Primary Cardholder Name and DOB: _____ ___/___/___

(If Minor) Parents Name and DOB: _____ ___/___/___

Parents Phone: _____

How did you hear about us? Please include names.

◯ Our Website ◯ Internet Search ◯ Radio ◯ TV ◯ Other _____

Newspaper/Magazine: ◯ Vero Beach Magazine ◯ Indian River Magazine

◯ Vero Beach 32963 ◯ Press Journal ◯ Vero/Seb. News

◯ Screening ◯ Insurance Company ◯ Referred by: _____

(Doctor, Optometrist, Friend/Family)

DO NOT WRITE BELOW THIS LINE

ACCOUNT NUMBER: _____

DATE REGISTERED: _____ REGISTERED BY: _____