

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: M F 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?:

Minotty O'Brien Tate Reinauer Sayed Khodadadeh

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: _____