NEW VISION EYE CENTER ~ PATIENT INFORMATION SHEET

PATIENT DEMOGRAPHICS

Patient Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Street Address (if different from mailing): _____

Primary Phone: _____ Cell Phone: _____

Patient Employer:_____ Employer Phone: _____

Email Address:_____

Patient Date of Birth: _____ Sex: M or F Marital Status: _____

Patient SS #: _____

Emergency Contact Name: _____ Relation: _____

Emergency Contact Phone: _____

The information below is required for Electronic Medical Records:

Pharmacy Name and Location: _____

Preferred Language: _____

Ethnicity: ___ Not Hispanic or Latino ___ Hispanic or Latino

Race: ___ Asian ___ Black or African American ___ White ___ Other

___ American Indian or Alaska Native ___ Native Hawaiian or Other Pacific Islander

Which Doctor are you here to see?

___ Dr. Minotty ___Dr. O'Brien ___ Dr. Tate ___ Dr. Reinauer

INSURANCE INFORMATION

Primary Insurance: _____ Secondary Insurance: _____

Primary Cardholder Name and Date of Birth: _____

(If Minor) Parents Name: _____

Parents Date of Birth: _____ Parents Daytime Phone: _____

How did you hear about us? Please include names.

Our Website _____ Internet Search _____ Radio _____ Other _____

Newspaper _____ Screening _____ Insurance Company _____ TV _____

Referred by M.D. _____

Referred by Optometrist _____

Referred by Friend/Family - Yes or No If yes, whom? _____

DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY

Account Number: _____

Date Registered: _____ Registered By: _____

Earning trust, one patient at a time.