NEW VISION EYE CENTER PATIENT INFORMATION SHEET

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 to Contact: _____

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 ○ Piette ○ Gordon

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 select all that apply.

☐ Our Website
☐ Internet Search
☐ Social Media
☐ Digital Advertising
☐ Screening
☐ Radio
☐ TV
☐ Direct Mail
☐ Email

Advertising or Article:
☐ Vero Beach 32963
☐ Vero/Sebastian News
☐ Vero Beach Magazine
☐ Indian River Magazine
☐ Spacecoast Magazine
☐ Press Journal
☐ Heartbeat of the Treasure Coast
☐ Guide to Medical Services
☐ Senior Services Guide
☐ _____

☐ Referred by: _____
(Doctor, Family or Friend Name)

☐ Other: _____

DO NOT WRITE BELOW THIS LINE

ACCOUNT NUMBER: _____

DATE REGISTERED: _____ REGISTERED BY: _____