# Prime Eye Care, P.A.

## Patient Information

| ❑ Mr. ☐ Mrs. ❑ Ms. ☐ Dr. | First Name | Middle | Last | Suffix (Jr., Sr. etc.) |
|---|---|---|---|---|

| Marital Status (Single, Married, etc.) | Sex ☐ M ☐ F | Social Security Number - - | Date of Birth / / |
|---|---|---|---|

Street Address

| Street Address 2 (Apt) | City, State, and Zip |
|---|---|

| Home Phone ( ) | Work Phone ( ) | Mobile Phone ( ) |
|---|---|---|

| E-mail | Race (optional) | Ethnicity (optional) |
|---|---|---|

| Employer | Occupation | Employer Address |
|---|---|---|

| Primary Care Physician | Primary Care Physician's Phone ( ) |
|---|---|

Referred to Clinic by (May check more than one box): ❑ Dr. ❑ Insurance Plan ❑ Hospital ☐ Family ☐ Friend ☐ Close to Home/Work ☐ AT&T Yellow Pages ☐ Church Bulletin ☐ Internet

| Name of Who or What Referred You (if applicable) | Other Family Members Seen Here |
|---|---|

## Person Responsible For Bill (If Not Patient)

| ❑ Mr. ☐ Mrs. ❑ Ms. ☐ Dr. | First Name | Middle | Last | Suffix (Jr., Sr. etc.) |
|---|---|---|---|---|

| Relationship to Patient | Marital Status (Married, etc.) | Date of Birth / / | Sex ☐ M ☐ F | Social Security Number - - |
|---|---|---|---|---|

Street Address

| Street Address 2 (Apt) | City, State, and Zip |
|---|---|

| Home Phone ( ) | Work Phone ( ) | Mobile Phone ( ) |
|---|---|---|

| Is This Person A Patient Here? ☐ Yes ☐ No | May Personal Health Information be Released to this Person? ☐ Yes ☐ No |
|---|---|

## Insurance Information (Please Give Your Insurance Cards To The Receptionist)

| Is This Patient Covered By Any Medical Insurance? ☐ Yes ☐ No | Is Insurance Under Patient or Guardian Listed Above? ☐ Yes ☐ No (If no, please fill out information below) |
|---|---|

| ❑ Mr. ☐ Mrs. ❑ Ms. ☐ Dr. | First Name | Middle | Last | Suffix (Jr., Sr. etc.) |
|---|---|---|---|---|

| Relationship to Patient | Marital Status (Married, etc.) | Date of Birth / / | Sex ☐ M ☐ F | Social Security Number - - |
|---|---|---|---|---|

Street Address

| Street Address 2 (Apt) | City, State, and Zip |
|---|---|

| Home Phone ( ) | Work Phone ( ) | Mobile Phone ( ) |
|---|---|---|

| Is This Person A Patient Here? ☐ Yes ☐ No | May Personal Health Information be Released to this Person? ☐ Yes ☐ No |
|---|---|