Prime Eye Care, P.A.

Patient Information

First Name | Middle Initial | Last | Suffix (Jr., Sr. etc.)

Nickname	Birth Sex	Social Security Number	Date of Birth	Marital Status (Single, Married, etc.)
	◯M ◯F			

Street Address

Street Address 2 (Apt)	City	State	Zip

Home Phone	Work Phone	Mobile Phone to receive text reminders

E-mail (required for patient portal access)	Do you wish to receive mobile text reminders? ◯ Yes ◯ No (You may opt out at any time)

Employer	Preferred contact method (Phone, Text, Email)

Primary Care Physician	Primary Care Physician's Phone

How did you hear about us? ☐ Doctor ☐ Insurance ☐ Hospital ☐ Family ☐ Friend ☐ Church Bulletin ☐ Internet ☐ Other

Preferred Pharmacy	Pharmacy City	Pharmacy Phone or Street Intersection

Parent or Guardian

First Name | Middle Initial | Last | Suffix (Jr., Sr. etc.)

Nickname	Birth Sex	Social Security Number	Date of Birth	Marital Status (Single, Married, etc.)
	◯M ◯F			

Relationship to Patient	Is this person a patient here? ◯ Yes ◯ No	May personal health information be released to this person? ◯ Yes ◯ No

Street Address (Check if Same as Patient ☐)

Street Address 2 (Apt)	City	State	Zip

Home Phone	Work Phone	Mobile Phone