Patient Information

Last name_____First_____M.I.____

Address_____Apt_____

City_____State_____Zip_____

Preferred Phone (_____)_____Home / Cell / Work Please circle one

Alternate Phone (_____) _____Home / Cell / Work Please circle one

Other Mailing Address_____Apt_____

City_____State_____Zip_____

Birthday _____/_____/_____ Age_____ Soc. Sec. # _____ Sex: Female / Male

I authorize Palm Beach Eye Center to contact me at the following email address:_____

Are you ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED?

Primary Language:
☐ English
☐ Spanish
☐ Creole
☐ French
☐ Other _____

Ethnicity:
☐ Hispanic/Latino
☐ Not Hispanic/Latino
☐ Unknown
☐ Decline to Specify

Race:
☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or other Pacific Islander
☐ White
☐ Other _____
☐ Decline to Specify

Employer _____ Phone (_____)_____

Address _____ City _____ State _____ Zip _____

Whom may we thank for referring you to our office? _____

Primary Care Physician _____ Phone (_____)_____

Name of person to contact in case of an emergency _____

Relationship _____ Phone (_____)_____Phone (_____)_____

Do you have a living will? ☐ Yes ☐ No

INSURANCE Are you personally responsible for the payment of your fees? ☐ Yes ☐ No If no, who is?

Name_____Relationship_____DOB_____

Address _____ City _____ State _____ Zip _____

☐ Medicare #_____ ☐ Medicaid #_____

☐ Blue Cross/Blue Shield_____Type_____Subscriber_____

☐ Other_____Policy #_____Phone (_____)_____

We must have a copy of all insurance cards and identification in order for the Palm Beach Eye Center to process/submit any claims for you. The above information is true and correct.

Signature_____**Date**_____

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