PATIENT INFORMATION

NAME:

____ ___M / F___ ____/_____/_____ __________

Last Name First Name MI Sex Date of Birth Birth State

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

ADDRESS:

____

Street

____

City State Zip Code

____

Country

COMMUNICATION:

Preference: (please check one)

☐ Phone ☐ US Mail ☐ E-Mail ☐ Text

Telephone Numbers:

(____)______________________

Home

(____)_____________________________

Work Ext.

(____)______________________ __________________

Cell Cell Carrier (if preference is text)

____

E-Mail Address

INFORMATION:

____

Social Security #

____

Primary Language

____

Special Needs (ex. wheelchair, hard of hearing, etc.)

Race: (please check one)

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Pacific Islander
☐ White
☐ Other

Ethnicity: (please check one)

☐ Unknown
☐ Not Hispanic or Latino
☐ Hispanic or Latino

____

Mother's Maiden Name

____

REFERRED BY:

☐ Doctor:_____________________ ☐ Relative/Friend ☐ Website ☐ Insurance ☐ Phone Book ☐ Other

Primary Care Physician Name: ____

Address & Phone Number: ____

____

NEAREST RELATIVE:

_______________________________ ____

Name Address

_______________________________ (____)______________________ (____)_________________________

Relationship to patient Home Phone # Work Phone #

Is it ok to release medical information about you to this person? ☐ Yes ☐ No

(____)______________________ _____________________________

Cell Phone # E-Mail Address

PERSON RESPONSIBLE INFORMATION

(Must be parent or legal guardian if patient is under 18 years of age)

□ Check here if person responsible is same as patient.

NAME:

Last Name _______________ First Name _______________ MI ____ Relationship to patient _______________

Social Security # _______________

ADDRESS:

Street _______________ Home Phone # (   ) _______________

City _______________ Work Phone # (   ) _______________ Ext.

State _______________ Zip Code _______________ E-Mail Address _______________

INSURANCE INFORMATION

PRIMARY INSURANCE: □ Check here if subscriber is retired.

Insurance Plan Name _______________ Subscriber's Name _______________

Policy/ID # _______________ Subscriber's Date of Birth _______________

Group # (if applicable) _______________ Subscriber's Employer _______________

SECONDARY INSURANCE: □ Check here if subscriber is retired.

Insurance Plan Name _______________ Subscriber's Name _______________

Policy/ID # _______________ Subscriber's Date of Birth _______________

Group # (if applicable) _______________ Subscriber's Employer _______________

VISION PLAN: (VSP, EyeMed, etc.) □ Check here if subscriber is retired.

Vision Plan Name _______________ Subscriber's Name _______________

Policy/ID # _______________ Subscriber's Date of Birth _______________

Group # (if applicable) _______________ Subscriber's Employer _______________

I request that payment under Medicare or any other health insurance program be made either to me or to Massachusetts Eye Associates, PC, as directed, on any benefits for any charges for this service.

Signature _______________ Date _______________

Print Name _______________