The Ophthalmology Group, LLP

PATIENT INFORMATION

Patient Full Name: _____ *Date of Birth:* _____

*SSN #:*_____ *Gender*_____ *Marital Status:* _____

Address: _____ *City,State,Zip:*_____

*Telephone #:*_____*Cell Phone #:*_____

*Alternate Phone #*_____*Email address:* _____

*Emergency Contact (Name):*_____ *Phone #*_____*Relationship*_____

*Employer (Name/Phone #):*_____

Primary Care Physician: _____*Referring Physician:* _____

Preferred Pharmacy: _____ *Location of Pharmacy:* _____

Preferred Language: □ *English* □ *Spanish* □ *Sign Language* □ *Other*_____

Ethnicity: □ *Hispanic or Latino* □ *Non-Hispanic or Latino* □*Unknown*

Race: □ *White* □ *African American* □ *Native Hawaiian or Pacific Islander* □ *Asian* □ *American Indian* □ *Alaska Native* □ *Black & White* □ *Asian & White* □ *Black & Asian* □ *Unknown/ Refused*

If you would like your Personal Health Information to be shared with any other person please fill in the information below. We will ask this person to verify their relationship with you, including your date of birth.

1) _____

Full Name *Relationship*

2) _____

Full Name *Relationship*

2) _____

Full Name *Relationship*

Insurance Information

(Please Provide Office with Insurance Cards)

Primary Insurance

Insurance Company Name: _____ *Insured Member Name:* _____

Insured Date of Birth: _____ *Relationship to Patient:* _____

Secondary Insurance or Vision Plan

Insurance Company Name: _____ *Insured Member Name:* _____

Insured Date of Birth: _____ *Relationship to Patient:* _____

_____ _____

Signature of Patient *Date*