SIGHT EYE CLINIC, P.C.

2016

Thank you for choosing the Sight Eye Clinic for your vision and health needs. Since we are committed to providing you with the highest standard of care, we kindly ask our patients to update this form on an annual basis.

DATE ______________________________

PATIENT INFORMATION

LAST NAME:				FIRST NAME:			M.I.
SOCIAL SECURITY #:			BIRTHDATE:			MALE	FEMALE
STREET ADDRESS:			CITY:		STATE:		ZIP:
RACE:	Caucasian	African American	Asian	Hispanic	Other	Decline	
PREFERRED LANGUAGE:		English	Spanish	Other			
ETHNICITY:		Hispanic/Latino	NOT Hispanic/Latino			Unknown	Decline
MARITAL STATUS:		Married	Widowed	Single	Divorced		
PREFERRED PHONE:				ALTERNATE PHONE:			
EMAIL ADDRESS:							
PRIMARY CARE DOCTOR:				REFERRING DOCTOR:			
IN CASE OF AN EMERGENCY, WHO SHOULD BE NOTIFIED?						PHONE	
FINANCIAL INFORMATION				Please fill out all insurances that apply			
PRIMARY MEDICAL INSURANCE: (Will be billed if exam has a medical diagnosis)/					**EMPLOYER:**		
SUBSCRIBER NAME: (If other than patient)					Address:		
SUBSCRIBER BIRTHDATE:				SUBSCRIBER SOCIAL SECURITY #:			
SECONDARY MEDICAL INSURANCE:							
SUBSCRIBER NAME: (If other than patient)							
SUBSCRIBER BIRTHDATE:				SUBSCRIBER SOCIAL SECURITY#:			
VISION INSURANCE: (for routine eye exams, glasses, or contact lenses)							
SUBSCRIBER NAME: (If other than patient)							
SUBSCRIBER BIRTHDATE:				SUBSCRIBER SOCIAL SECURITY #:			