Legal Name:_____ Date of birth:_____

Address: _____ City/State:_____ Zip:_____

Telephone (Home): _____ (Work): _____ (Cell): _____

Email Address: _____

SSN:_____ Sex: M F

Emergency Contact and Telephone: _____

Preferred Language: ___ English ___ Other:_____

Race: ___ American Indian/Alaska Native ___ Asian ___ Black/African American

___Native Hawaiian/Other Pacific Islander ___ White ___ Other ___Decline

Ethnicity: ___ Hispanic/Latino ___ Non Hispanic/Latino ___ Decline

Complete the following if the patient is under 18 or under another party's insurance:

Parent's/Guardian's Legal Names: (1) _____ DOB: _____SSN:_____

(2) _____ DOB: _____SSN:_____

What is your occupation? _____ Employer: _____

Do you use tobacco products? Y N If yes, what type & how often?_____

Do you drink alcohol? Y N If yes, how often? _____

Marital Status M S W D Spouse's Name: _____DOB:_____

Name of last **eye** doctor: _____ Date of last **eye** exam: _____

Name of your medical doctor: _____ Location_____

Phone Number:_____ Date of last physical exam: _____

Height: _____ Weight: _____lbs Preferred Pharmacy & Location: _____

Please list who we may discuss your care/account with:

1: _____ _____
Name Relationship

2: _____ _____
Name Relationship

3: _____ _____
Name Relationship

4: _____ _____
Name Relationship

I authorize Eaton Rapids Eye Care, P.C. to share my health information with the above named people as necessary to facilitate my care. I will inform Eaton Rapids Eye Care, P.C. if I ever wish to add or delete individuals from this list. I authorize Eaton Rapids Eye Care, P.C. to share my medical information with other medical providers if I am referred to another provider for advanced care and/or to update my primary care provider and/or a referring doctor on my status. I understand I am ultimately responsible for payment of services rendered to me. I understand that Eaton Rapids Eye Care P.C. will bill my insurance and I am responsible for any balance not covered, as well as any co-payments and/or deductible. I understand I will be charged any collection fees if my balance is forwarded to a collection agency. I also authorize the release of medical information necessary to process my insurance claim to my insurance carrier(s).
I acknowledge I was offered a copy of Eaton Rapids Eye Care P.C. Notice of Privacy Practices.

_____ _____
Signature of patient or person authorized to sign for patient Relationship of authorized person

_____ _____
Printed name of patient or authorized person Date