

Legal Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Cell): \_\_\_\_\_

Email Address: \_\_\_\_\_

SSN: \_\_\_\_\_ Birth Gender: 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