



## Eye Site Patient Information

*Please provide a Photo ID and current Insurance Cards to our Front Desk Staff upon Check-In.*

<b>Title, Last Name, First Name</b>	<b>Date of Birth</b>	<b>Gender</b>	<b>Chart #</b>
<b>Mailing Address</b>	<b>Social Security Number</b>		
	<b>Preferred Language:</b> <b>Race:</b> <b>Ethnicity:</b>		
<b>Contact Information</b>	<b>Email</b>		
	<b>Preferred Communication Method (Circle One)</b> <i>Home    Work    Mobile    Email</i>		
Home Phone			
Cell Phone			
<b>Emergency Contact</b>	<b>Primary Care Doctor</b>		
Name	Physician Name		
Relationship	Office Phone		
Phone			
<b>Insurance Company/Policy ID (Please present cards)</b>	<b>Secondary Referring Doctor</b>		
Primary: _____	Physician Name		
Secondary: _____	Office Phone		
<b>Do you have Routine Vision Insurance?</b> Yes / No If so please state the coverage below: Vision: _____			

**\*Patient/Guardian Signature**

**Date**

*\*I have reviewed all of the above information and have found it to be accurate to the best of my knowledge. I have notified the office of any changes that need to be made.*