SUMMIT Eye Care P.A.
Advanced Eye Care Solutions

Patient Information Form

Date_____ **Social Security #**_____

Name of Family Doctor_____ **Name of Referring Doctor**_____

Miss Ms. Mrs. Mr. (Marital Status: Single Married Div Sep Widow Life Partner**)**

Name_____ **Birthdate**_____ **Age**_____
First Middle Last

Address_____ **County**_____

City_____ **State**_____ **Zip**_____

Email Address_____ **Employer**_____

Home Phone_____ **Occupation**_____

Cell Phone _____ **Work Phone**_____

Preferred Language
- o English
- o Spanish
- o Unknown
- o Other

Ethnicity
- o Hispanic or Latino
- o Not Hispanic or Latino
- o Refused / Declined

Race
- o Alaska Native
- o American Indian
- o Asian
- o Black or African American
- o Caucasian / White
- o Native Hawaiian or Other Pacific Islander
- o Multiracial
- o Refused / Declined

New Patient: How did you learn of our office?
O Family Dr. O Family O Friend O Yellow Page O Insurance List O Other_____

INSURANCE INFORMATION

Primary Insurance_____ **Secondary Insurance**_____
Primary Policy ID#_____ **Secondary Policy ID#**_____
Policy Holder Name_____ **Secondary Policy Holder Name**_____
Relation_____ **Birthdate**_____ **Relation**_____ **Birthdate**_____
Vision Plan_____

UNDER 18 YEARS OF AGE OR A STUDENT

Name of Financially Responsible Person_____ **Relation**_____
Address_____
Phone_____ **Alternate Phone**_____

EMERGENCY CONTACT

Name_____ **Relation**_____ **Phone**_____

PRIVACY RELEASE: Due to the privacy regulations, permission is required before any information can be shared with others. If you have anyone who could possibly contact our office on your behalf and want us to share your health information, please list their names below.

Name_____ **Relation**_____ **Phone**_____
Name_____ **Relation**_____ **Phone**_____

Preferred Pharmacy_____

Do we have permission to leave appointment confirmation on your answering machine? O YES O NO

Signature_____