Patient Information Date_____

Name_____
First Middle Last

Mailing Address_____
City State Zip Code

Date of Birth_____Age_____Male/Female_____Social Security#_____

Please check [_]Single [_]Married [_]Widowed [_]Divorced [_]Minor

[_] Home Telephone#_____[_]Cell phone/text#_____[_]Email_____

How do you want us to contact you? Please check the appropriate box normal text message rates apply.

Employer_____Employer's Telephone#_____

Whom to notify in emergency (nearest relative-not living with you)

Name_____Relationship_____Telephone#_____

If patient is a minor please complete (under 18 years old or covered by parents on insurance)

Name of Father_____Date of Birth_____Telephone#_____

Employer_____Telephone#_____

Name of Mother_____Date of Birth_____Telephone#_____

Employer_____Telephone#_____

PLEASE CHOOSE ONE:

Race:
- ☐ American Indian/ Alaska Native
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian/Pacific Islander
- ☐ Latin American
- ☐ White
- ☐ Decline to Specify

Language:
- ☐ English
- ☐ French
- ☐ German
- ☐ Italian
- ☐ Japanese
- ☐ Portuguese
- ☐ Russian
- ☐ Spanish
- ☐ Other
- ☐ Decline to Specify

Ethnicity:
- ☐ African American
- ☐ American
- ☐ American Indian
- ☐ Chinese
- ☐ European American
- ☐ Hispanic/Latino
- ☐ Jewish
- ☐ Not Hispanic/Latino
- ☐ Unknown
- ☐ Decline to Specify

INSURANCE AND PRIVACY INFORMATION

✸We Are Not Providers for Any Vision Plans✸

Name of Primary Insurance_____ ID#_____

Name of Policyholder_____Relationship to Patient_____

Birthdate of Policyholder_____Social Security # of Policyholder_____

Name of secondary insurance_____ID#_____

Name of Policyholder_____Relationship to Patient_____

Birthdate of Policyholder_____Social Security # of Policyholder_____

RELEASE OF INFORMATION, PRIVACY PRACTICES & FINANCIAL AGREEMENT

Please list those to whom we may discuss your diagnosis and treatments. I authorize the Henry Eye Clinic to discuss my medical information with the following people:

Name_____Relationship to Patient_____Phone_____

Name_____Relationship to Patient_____Phone_____

Please list other family members who are seen at the Henry Eye Clinic:

Name	Date of Birth	Name	Date of Birth

I authorize Henry Eye Clinic physicians and staff to preform eye examination services for me, including dilation and diagnostic testing as necessary. I have received the "Notice of Privacy Practices," and I agree to the Henry Eye Clinic Financial Agreement.

Signed_____**Date**_____