Eyesight Associates
A Division of Gayton Health Centre

PATIENT INFORMATION

Legal First Name _____ Middle _____ Last _____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ (Circle) Male / Female (Circle) Single / Married / Widowed / Separated / Divorced

Mobile Phone:_____ Preferred Method of Contact (Please Circle All That Apply): Home # / Work # / Mobile # / Written Communication / E-Mail / Text

Date of Birth_____ Age:_____ SSN#:_____

Race (Circle)
American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or Other Pacific Islander / white

Ethnicity (Circle)
Hispanic / Non-Hispanic

Preferred Language (Circle): English / French / Italian / Japanese / Portuguese / Russian / Spanish / Other:_____

Patient Employed By:_____ Wk Phone:_____

Are You Retired? Yes / No Date Retired:_____ (Month/Year) E-Mail Address:_____

How did you learn about our office?_____

Name of Doctor who referred you:_____ City:_____ Phone #:_____

Whom to notify in case of emergency?:__ _____ Home Phone:_____ Wk Phone:_____

SPOUSE INFORMATION

Name:_____ Employer:_____

Date of Birth:_____ Work Phone:_____

SS #:_____ Retired? Yes / No Date Retired:_____

MUST COMPLETE IF UNDER 18 OR USING GUARDIAN'S INSURANCE

Father

Name:_____

Date of Birth:_____

SS #:_____

Employer:_____

Work Phone:_____

Mother

Name:_____

Date of Birth:_____

SS #:_____

Employer:_____

Work Phone:_____

************PLEASE PRESENT INSURANCE CARDS TO THE RECEPTIONIST************