

PATIENT INFORMATION

DEMOGRAPHICS

Name Last First Mi			Date	
Address			Social Security #	
City			Birthdate	Age
			Race	Sex
State	County	Zip Code	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Home Phone		Work Phone	Email Address	
Employer Name/Address			Position / Department	
Spouse			Work Phone	
Emergency Contact			Emergency Phone	
Special Needs <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Walker <input type="checkbox"/> Wheel Chair <input type="checkbox"/> Other <input type="checkbox"/> Translator <input type="checkbox"/> Language_____				

BILLING

Guarantor (Financially Responsible Person) Name			Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other	
Street Address			Phone	
City			State	Zip
Primary Insurance	Policy Holder	Policy ID#	Social Security #	Insured's B/D
Secondary Insurance	Policy Holder	Policy ID#	Social Security #	Insured's B/D
Send Workers Compensation To			Authorized By/Position	Date of Incident

REFERRAL

Whom may we thank for telling you about our practice?			<input type="checkbox"/> Friend/Family <input type="checkbox"/> Patient <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Sign <input type="checkbox"/> Screening <input type="checkbox"/> Newspaper <input type="checkbox"/> Radio <input type="checkbox"/> Other_____	
I give permission for Hunkeler Eye Institute to send a Thank You letter to my referral. Signature_____			<input type="checkbox"/> MD/OD_____	
			<input type="checkbox"/> Optometrist_____	
Street Address		City	State	Zip
Primary Care Doctor Name		Optometrist Name	Phone	
Street Address		City	State	Zip