HUNKELER EYE INSTITUTE

Patient Information

Demographics

Name Last First			Middle Name		Date		
Street Address			SSN#				
City			Special Needs ☐ Wheel Chair ☐ Walker ☐ Hearing Impaired ☐ Other ☐ Translator, what language _____				
State	County	Zip Code	Date of Birth	Age	Race	☐ Male ☐ Female	
( ) Home Phone	( ) Work Phone		Email		☐ Single ☐ Divorced ☐ Married ☐ Widowed Marital Status		
Employer Name/Address			Position/Department				
Spouse's Name			Spouse's Date of Birth		( ) Spouse's Work Phone		
Emergency Contact			( ) Emergency Contact Phone Number				

Billing

Guarantor (Person Responsible for Payment of Bill)		☐ Self ☐Spouse ☐Parent ☐ Other Relationship to Patient		
Street Address		( ) Phone		
City		State		Zip Code
Primary Insurance	Policy Holder	Policy ID#	SSN#	Insured's Date of Birth
Secondary Insurance	Policy Holder	Policy ID#	SSN#	Insured's Date of Birth
Send Workers Compensation to:		Authorized by/Position		Date of Incident

Referral

Whom may we thank for telling you about Hunkeler Eye Institute?	☐ Friend/Family ☐ Patient ☐ Yellow Pages ☐ Radio ☐ Newspaper ☐ Sign ☐ Screening ☐ Other
Sign if we have your permission for Hunkeler Eye Institute to send a Thank You letter to the person who referred me. _____	☐ MD/OD _____ ☐ Optometrist _____

Primary Care Physician (PCP) Name	PCP Address	PCP Phone
Optometrist Name	Optometrist Address	Optometrist Phone