PATIENT INFORMATION FORM

Today's Date:_____

Last Name: _____ **First Name:** _____ **MI:**_____

Address: _____ **Preferred Name:**_____

City: _____ **State:** _____ **Zip:** _____

Home Phone: (____) _____ **Cell:** (____) _____ **Work Phone:** (____) _____ **Ext.**___

Email:_____ **Social Sec. #**_____-_____-_____

Birthdate:_____/_____/_____ **HT**_____ **WT**_____ **Male:**_____ **Female:**_____

Ethnicity:____ Hispanic or Latino Origin ____ Non Hispanic or Latino Origin

Preferred Language: ____English ____Spanish ____Other _____

Race: ___White ___African American ___Alaskan Indian ___American Indian ___Asian ___Pacific Islander ___Other

Place of Employment: _____ **Occupation:**_____

Spouse/Partner's Name: _____

If a minor - Father's Name:_____ **Mother's Name**_____

and/or Legal Guardian: _____

Family Physician: _____ **Last Health Physical:**_____

Pharmacy: _____

HEALTH INFORMATION RELEASE CONSENT

I hereby give consent to the Eye Care Center of Newton to communicate to me any health information via the following methods (check any that may apply):

☐ **Voicemail or Answering Machine** ☐ **Home Phone** ☐ **Cell** ☐ **Work Phone**

☐ **Email** ☐ **Same email as above** **Other** _____

Please fill out the following if you would like us to be able to discuss your health information with others (list up to two): (If patient is a minor, health information will be discussed with both parents unless otherwise specified.)

Name	Relationship to Patient	Phone Number
_____	_____	_____
_____	_____	_____