

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
_____	_____	_____

Name	Relationship to Patient	Phone Number
_____	_____	_____