CAMPUS EYE CENTER

NEW PATIENT INFORMATION/UPDATE

Welcome to our office. Please complete both sides of this form and return it to the receptionist who will use the information to prepare your chart. PLEASE PRINT.

Patient Name:_____

I consent to the disclosure of my "protected health information" to

_____

who is involved in my medical care.

Name of Spouse _____

Spouse's Employer _____

Spouse's Work Address _____

_____

signature/date

Complete if under 18 years of age or a student:

Parents' names _____

Parents' employers _____

How did you hear about our practice?
Please check one:

- ❑ Referred by Doctor
- ❑ Friend or relative recommended
- ❑ LGH Physician Referral Service
- ❑ A Lecture by one of our physicians
- ❑ Yellow pages ad
- ❑ Newspaper ad
- ❑ Magazine ad
- ❑ Campus Opticians
- ❑ Other

Please note: For all vision insurances, we request payment for services at the time of your visit. Reimbursement will then be made directly to you by your insurance carrier.

CAMPUS EYE CENTER

NEW PATIENT INFORMATION/UPDATE

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

Address:_____

Patient's SSN:_____ **Age:**_____ **DOB:**_____

Country:_____ **__Male __Female**

Mother's Maiden Name:_____ **Mother's Birth State**_____

Family Doctor:_____ **Marital Status:**_____

Phone: Home:_____ **Work:**_____ **Cell:**_____ **Carrier:**_____

Email:_____

Primary Language: __English __Spanish __French __German __Other _____

Special Needs: __Hearing Impaired __Wheelchair __Other_____

Race: __White __Black or African American __Asian __Other

__Native Hawaiian/Other Pacific Islander

Ethnicity: __Unknown __Not Hispanic or Latino __Hispanic or Latino

Occupation:_____ **Employer:**_____

Emergency Contact:_____ **Phone:**_____

Relationship:_____

Insurance: Primary_____

Secondary_____

Insured's Name:_____ **Insured DOB:**_____

Insured's SSN:_____ **Relationship:**_____