

Chart # _____

Acct. # _____

Date _____



PATIENT INFORMATION FORM

Last Name _____ First Name _____ MI _____
Street _____ Apt. Number _____
City _____ State _____ Zip Code _____ E-Mail _____
Date of Birth ____/____/____ Age _____ Social Security Number _____ - _____ - _____
Home Phone _____ Cell Phone _____ Work Phone _____
Marital Status: Single___ Married___ Separated___ Divorced___ Widowed___ **Gender:** Male___ Female___
Emergency Contact Last Name _____ First Name _____ MI _____
Relationship to Patient _____ Phone _____

Medical Insurance Information for Patient

Primary Insurance _____ Policy Number _____
Secondary Insurance _____ Policy Number _____
Other Insurance _____ Policy Number _____
Employer _____ Employer's Address _____

Responsible Party Information

Only complete if patient is 18 years old or younger or has a legal representative.

Last Name _____ First Name _____ MI _____
Address _____ Apt. Number _____
City _____ State _____ Zip Code _____ E-Mail _____
Date of Birth ____/____/____ Age _____ Social Security Number _____ - _____ - _____
Home Phone _____ Cell Phone _____ Work Phone _____
Relationship to Patient _____ Employer _____

AUTHORIZATION TO TREAT

I AUTHORIZE Rockingham Eye Associates to treat me:

Signature of patient or legal representative

Date