Columbia Eye

PATIENT INFORMATION (PLEASE PRINT)

Patient Name _____ _____
Last First Middle Occupation

Address _____
Street City State Zip

DOB: _____ Soc. Sec. # _____ Sex: _____

Race: ☐ White ☐ Black ☐ Asian ☐ American Indian or Alaskan Native ☐ Native Hawaiian ☐ Declined to Specify

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Declined to Specify

Email _____ Home Phone _____ Cell Phone _____

Preferred Method of Contact for Appointment Reminders: Home Phone _____ Cell Phone/Text _____ Email _____

Name of Spouse _____ Phone Number _____

Emergency Contact: Name _____ Phone Number _____

Relationship _____

RESPONSIBLE PARTY

Name _____ Relationship _____

Address _____ Telephone Number _____

INSURANCE INFORMATION

Primary Insurance _____ Secondary Insurance _____

Tertiary Insurance _____

Insurance coverage for your medical care is helpful since it reduces your potential liability, and we are glad to help you complete claim forms. However, financial agreement rests with you and not the insurance company.

Date _____ Signature _____