PATIENT DATA

Sun State Eye Care

TODAY'S DATE: _____ DATE OF BIRTH: _____

PATIENT NAME: _____

Last First Middle

ADDRESS: Street: _____

City:_____ State: _____ Zip: _____

Billing Address – If different: Street: _____

City:_____ State: _____ Zip: _____

(Check box for preferred method of communication)

PHONE: _____ _____ _____

Home☐ Cell: Call ☐ Text ☐ Work ☐

EMAIL: ☐ _____

Do you give Sun State Eye Care permission to leave messages? ☐ Yes ☐No

RACE:

☐ White

☐ Black/African American

☐ Asian

☐ American Indian/Alaska Native

ETHNICITY:

☐ Not Hispanic or Latino

☐ Hispanic or Latino

☐ Native Hawaiian/Pacific Islander

PREFERRED LANGUAGE: ☐ English ☐ Spanish ☐ Other: _____

FAMILY DOCTOR: _____

Address: _____

Phone: _____ Fax: _____

PREFERRED PHARMACY: _____

Address: _____

EMERGENCY CONTACT: _____ Relationship: _____

Phone number: _____

Who may we talk to about your medical concerns?

Name Relationship

Name Relationship

Referred to our office by: _____

Patient Signature: _____