PATIENT INFORMATION FORM

River Valley EYE PROFESSIONALS

DATE: _____

Name: _____ Known by any other Name: _____
Last First MI

Birth date: _____ Sex: M☐ F☐ Social Security #: ___-___-___ Marital Status: S☐ M☐ D☐ W☐

Address _____
Street City State Zip County

Home Phone: (___) ___-___ Are calls allowed: Y☐ N☐ Daytime Phone: (___) ___-___ Are calls allowed: Y☐ N☐

Employer: _____ Work Phone: (___) ___-___ Occupation: _____ Emp. Status: FT☐ PT☐

Employer Address: _____
Street City State Zip County

Emergency Contact: _____ Relationship: _____ Day Phone: (___) ___-___

Spouse/Partner's Name: _____ Date of Birth: _____ Day Phone: (___) ___-___

Student: FT☐ PT☐ No☐ **If under 18 =>** Mother's Name: _____ Father's Name: _____

STATEMENT BILLING ADDRESS (PERSON TO WHOM BILL WILL BE SENT)

Name: _____ Social Security #: ___-___-___
Legal Last name Legal First Name Birth Date MI

Address: _____
Street City State Zip County

Home Phone: (___)___-___ Calls Allowed:Y☐ N☐ Work Phone: (___) ___-___ Calls Allowed: Y☐ N☐

Employer: _____
Street City State Zip County

POLICY HOLDER/INSURANCE

Policyholder: _____ Birth date: _____ Social Security #: ___-___-___ Relation to Patient: _____

Address: _____
Street City State Zip County

Employer Name: _____ Employment status: _____

Employer Address: _____
Street City State Zip County

Primary Insurance: _____ Policy No./ID#: _____ Group #: _____

Insurance Address: _____
Street City State Zip County

"We are required by state and federal law to ask you about your ethnicity, race, and primary language.

1. **Which of the following best describes you?**

   Hispanic or Latino ☐ Not Hispanic or Latino ☐

2. **Which of the following races best describes you?**

   ☐ American Indian or Alaskan Native
   ☐ Black or African
   ☐ Native Hawaiian/Other Pacific Islander
   ☐ Asian
   ☐ White
   ☐ Unknown

3. **What is your primary language?**