WINTER PARK OPHTHALMOLOGY

☐Mr ☐Mrs ☐Ms ☐Miss ☐Dr

Last Name _____ First Name _____ MI ___

Date of Birth _____/_____/_____ SSN _____-_____-_____
Mo Day Year

Gender ☐M ☐F

Race/Ethnicity: ☐American Indian or Alaska Native
☐Asian
☐Black or African American
☐Hispanic or Latino
☐Native Hawaiian or other Pacific Islander
☐White

Address _____

City_____ State ____ Zip _____

Home Phone _____ Work _____ Cell _____

Preferred Phone for contact: ☐Home ☐Work ☐Cell

Email Address _____

Occupation _____ Employer _____

Work Status: ☐Full Time ☐Part Time ☐Retired ☐Student ☐Not Working

Spouse/Guardian Name _____ Phone _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Primary Care Physician _____

Phone _____ Fax _____

Preferred Pharmacy Name and Location _____

PRIMARY INSURANCE

Name_____

Policy/ID number _____ Group number_____

Address_____

SECONDARY INSURANCE

Name_____

Policy/ID number _____ Group number_____

Address_____

INSURED (if other than self)

First Name _____ Last Name _____ MI __

Date of Birth _____/_____/_____ SSN _____-_____-_____ Gender ☐M ☐F

Address _____

Referred by ☐Physician ☐Friend ☐Family ☐Insurance Company ☐Other _____

Name _____ Phone_____ Fax_____

Please provide phone/fax if referred by a physician

Information Release

Please list the individuals with whom we may discuss details of your medical care. Please give full name and relationship, and list any information you do **not** want shared: _____

_____

_____

_____

Signature X _____ Date _____