EYE PHYSICIANS OF AUSTIN
Advanced Eye Care

Patient Information Form

Patient's Name: _____
(First) (MI) (Last)

Gender: M F **Date of Birth:** _____ **Social Security #:** _____

Mailing Address: _____
(Street) (City) (State) (Zip Code)

		Circle One		**Preferred Method of Contact**
Phone: (_____) _____	Okay to leave message/text?	YES	NO	☐
E-mail Address: _____				☐

***I understand that email is not a secure method of communication and that personal health information sent via email may not be private. Eye Physicians may occasionally send promotional information via email.*

Patient's Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Race: ☐ African American ☐ American Indian ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Other

Primary Language: _____

Emergency Contact Name: _____ **Relationship:** _____

Emergency Telephone: Phone: (____) _____

Patient's Primary Care Physician: _____ **Phone:** (_____) _____

Patient's Referring Physician: _____ **Phone:** (_____) _____

Insurance Subscriber's Name: _____

Subscriber's DOB: _____ **Relationship to Subscriber:** _____

Responsible Party: _____ **Phone:** (_____) _____
(if other than self)

_____ _____
Patient/Parent/Legal Guardian Signature **Date**