PATIENT INFORMATION

DEMOGRAPHICS

NAME LAST FIRST MI				DATE		
STREET ADDRESS				SOCIAL SECURITY #		
CITY				SPECIAL NEEDS ☐ WHEEL CHAIR ☐ WALKER ☐ HEARING IMPAIRED ☐ OTHER ☐ TRANSLATOR LANGUAGE _____		
STATE	COUNTY	ZIP CODE	BIRTHDATE	AGE	RACE	SEX
HOME PHONE ( )	WORK PHONE ( )	CELL PHONE ( )	MARITAL STATUS ☐ MARRIED ☐ DIVORCED ☐ SINGLE ☐ WIDOWED			
EMPLOYER NAME / ADDRESS			POSITION / DEPARTMENT			
SPOUSE			WORK PHONE ( )			
EMERGENCY CONTACT			EMERGENCY PHONE ( )			
MAY WE CONTACT YOU BY E-MAIL? ☐ YES ☐ NO E-MAIL ADDRESS: _____						

ARE YOU CURRENTLY IN A SKILLED NURSING FACILITY? YES ☐ / NO ☐

ARE YOU UNDER HOSPICE CARE? YES ☐ / NO ☐

BILLING

GUARANTOR (FINANCIALLY RESPONSIBLE PERSON) NAME			RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER	
STREET ADDRESS			PHONE ( )	
CITY			STATE	ZIP CODE
PRIMARY INSURANCE	POLICY HOLDER	POLICY ID #	SOCIAL SECURITY #	INSURED'S B/D
SECONDARY INSURANCE	POLICY HOLDER	POLICY ID #	SOCIAL SECURITY #	INSURED'S B/D

REFERRAL

WHOM MAY WE THANK FOR TELLING YOU ABOUT OUR PRACTICE? NAME	☐ FRIEND / FAMILY ☐ PATIENT ☐ YELLOW PAGES ☐ MD / DO _____ ☐ OPTOMETRIST _____		
I GIVE PERMISSION FOR DR. JEMSHED A. KHAN / DR. DYLAN L. YU TO SEND A THANK YOU LETTER TO MY REFERRAL SIGNATURE			
PRIMARY CARE DOCTOR NAME	PHONE ( )		
STREET ADDRESS	CITY	STATE	ZIP CODE