Looking Glass Eye Center Patient Information Form

Patient Name_____ **Date of Birth**_____

Social Security #_____

Mailing Address _____

City_____ **State**_____ **Zip**_____

Main #_____ **Alternate#**_____

Employer: _____ **Work #**_____

Email_____

Preferred Method of Contact: Main #_____ Alternate# _____ Mail _____ Email _____

Marital Status: Single _____ Married____ Widowed____ Other_____

Primary Language: English _____ Spanish _____ Other _____

Race:
White _____ Black/African American _____ American Indian/Alaska Native____
Asian_____ Native Hawaiian/Other Pacific _____ Decline to Answer _____

Ethnicity:
Not Hispanic/Latino_____ Hispanic or Latino_____ Decline to Answer _____

Primary Care Physician _____

Emergency Contact: _____ **Phone #**_____
Relationship to Patient: _____

PERSON RESPONSIBLE FOR ACCOUNT (PARENT/GUARDIAN)

Name _____ Date of Birth _____

Address (if different from above) _____

City _____ State _____ Zip_____

Phone #_____ Social Security # _____

Relationship to Patient _____

PLEASE PRESENT YOUR INSURANCE CARDS TO BE SCANNED AT TIME OF SERVICE

I authorize **Looking Glass Eye Center** to release any information to an insurance company that may be needed to process an insurance claim for myself or my dependent. I assign any payable benefits to **Looking Glass Eye Center**. With or without insurance, I understand that I am responsible for all charges incurred while under the care of **Looking Glass Eye Center**.

Signature_____ **Date** _____