Patient Demographic Form

Please PRINT

Pasco Vision Clinic

PATIENT INFORMATION

Last Name | **First Name** | **Middle Initial** | **Nickname/AKA**

Date of Birth | **Social Security Number** | **Gender** ❑ Male ❑ Female

Marital Status ❑ Married ❑ Single ❑ Divorced ❑ Life Partner ❑ Separated ❑ Widowed ❑ Other **Language** other than English

Race (Optional) ❑ Black – Non Hispanic ❑ American Indian/ Alaskan Native ❑ Hispanic ❑ Asian/Pacific Islander ❑ White – Non Hispanic ❑ Other

Home Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other Phone** ❑ Cell ❑ Pager ❑ Fax

Email Address | **Employment Status** ❑ Active Duty Military ❑ Child ❑ Disabled ❑ Employed Full-Time ❑ Employed Part-Time ❑ Homemaker ❑ Not Employed ❑ Retired ❑ Self Employed ❑ Student Full-Time ❑ Student Part-Time ❑ Other

Employer | **Employer Phone**

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician | **Referring Physician**

How did you hear about us? ❑ Billboard ❑ Employer ❑ Family Member ❑ Friend ❑ Health Fair Event ❑ Insurance ❑ Magazine ❑ Mail ❑ News ❑ Physician ❑ Radio ❑ Television ❑ Website ❑ Yellow Pages ❑ Other

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient ❑ Self (If self, skip to Emergency / Next of Kin) ❑ Spouse ❑ Parent ❑ Other

Last Name | **First Name** | **Middle Initial**

Date of Birth | **Social Security Number**

Home Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other Phone** ❑ Cell ❑ Pager ❑ Fax

Employer | **Employment Status** ❑ Active Duty Military ❑ Child ❑ Disabled ❑ Employed Full-Time ❑ Employed Part-Time ❑ Homemaker ❑ Not Employed ❑ Retired ❑ Self Employed ❑ Student Full-Time ❑ Student Part-Time ❑ Other

Employer Phone

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name | **First Name** | **Relationship to Patient**

Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other Phone** ❑ Cell ❑ Pager ❑ Fax

- *I authorize the release of any medical or other information necessary to process insurance claims.*
- *I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the physician or supplier for services rendered.*

Signature: _____ *Date:* _____