Prairie Eye Center LTD

Patient Information SS#: _____

(Please Print) Legal name required for insurance purpose

Name (first / middle / last) _____

DOB:_____ Gender (circle one) M / F Marital Status: (circle one) Single / Married / Divorced / Widowed

(*The following is strictly for insurance purposes and is not intended to neither categorize nor offend our patient's)

*Race (circle) Alaskan Native / Asian / African American / Canadian / Caucasian / Hispanic / Indian / Middle Eastern / Native American / Pacific Islander / More than one Race / Refused

*Ethnicity (circle) Hispanic or Latino/ Non-Hispanic or Non-Latino

*Preferred language (circle) English/Other

Mailing Address: _____

Zip:_____ City/State:_____ County:_____

Home# ( ) _____ Work# ( )_____ Cell# ( )_____

Preferred number (circle above Home, Work, Cell) E-mail address:_____

Employer:_____ Occupation:_____

PCP/Family Doctor_____ Office# ( )_____

Emergency Contact

Name (first / middle / last) _____

Phone# ( )_____ Cell# ( )_____

Relationship to patient: example (mother, father, relative, neighbor, friend)_____

Responsible party Information (Guarantor) if other than self

Name:_____ Birthdate:_____

Address_____ City/State_____ Zip_____

Relationship to patient:_____ Phone#_____

Insurance Information (please provide current insurance cards)

- Primary Ins Company: _____ ID/SSN:_____
- Policy Holder Name: _____ Birthdate:_____
- Secondary Ins Company: _____ ID/SSN:_____
- Policy Holder Name: _____ Birthdate:_____

Patient Signature: _____ Date:_____

****Parent Signature If Minor**