

Date:

Account Number:

PATIENT INFORMATION

First Name Middle Initial Last Name Suffix Nickname/AKA

Salutation: Mr. Mrs. Ms Other: Gender: Male Female
 Marital Status: Single Married Other: Language: English Spanish Other:

Date of Birth Social Security Number E-mail Address

Home Address City State Zip Code

Home Phone () Work Phone () Cell Phone ()

EMPLOYMENT INFORMATION

Employment Status: Employed Unemployed Military Retired Disabled
 Child Part-Time Student Full-Time Student Other:

Name of Employer Employer's Address

GUARANTOR INFORMATION

Same as Patient Relationship to Patient Social Security Number

First Name Middle Initial Last Name Phone Number ()

Mailing Address City State Zip Code

Alternate Mailing Address (Seasonal Resident) City State Zip Code

EMERGENCY CONTACT INFORMATION

Relationship to Patient Emergency Contact – Full Name Emergency Contact Phone Number ()

Home Address City State Zip Code

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician – Full Name Primary Care Phys. Phone Number ()

Referring Physician (If different than Primary Care Physician) – Full Name Referring Phys. Phone Number ()

How did you hear about us: Physician Family Member Friend Insurance Phone Book Internet
 News / Newspaper Mail Other:

MISCELLANEOUS INFORMATION

Is this a work-related injury? Is this injury related to a car accident? Date of Injury or Other Information
 Yes No Yes No

AGREEMENT STATEMENT

I certify that the above information as well as the insurance card(s) and photo identity presented at check-in are correct and true. If I am not the patient but am signing for a patient over 18 years of age or handicapped, I agree to provide with this form a copy of a legal document authorizing my signature. I acknowledge receipt of the Eye Care Center of Northern Colorado, P.C., Policies Form. By signing and dating this form, I am acknowledging that I have read, understand, and agree to this statement and all policies presented.

Signature of Responsible Party Date