Patient Information Form
(PLEASE PRINT)

EYE PHYSICIANS OF AUSTIN
Advanced Eye Care

Patient's Name_____
(First) (MI) (Last)

Gender: M F **Date of Birth:** _____ **Social Security #** _____

Mailing Address: _____
(Street) (City) (State) (Zip Code)

Responsible Party: _____ **Phone:** (____) _____

Phone Contacts:		**Circle One**	**Preferred Method of Contact**
Home: (____) _____	Okay to leave message?	YES NO	☐
Cell: (____) _____	Okay to leave message/text?	YES NO	☐
Work: (____) _____	Okay to leave message?	YES NO	☐
E-mail Address: _____			☐

***I understand that email is not a secure method of communication and that personal health information sent via email may not be private. Eye Physicians may occasionally send promotional information via email.*

Patient's Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced

Race: ☐ African American ☐ American Indian ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Other

Primary Language: _____

Emergency Contact Name: _____ **Relationship:** _____

Emergency Telephone: Cell (____) _____ Home (____) _____ Work (____) _____

Patient's Primary Care Physician: _____ **Phone: (**____) _____

Patient's Referring Physician: _____ **Phone:** (____) _____

Insurance Subscriber: _____ ☐ Insurance Subscriber same as patient

DOB: _____ **Relationship to Subscriber:** _____

Patient/Parent/Legal Guardian Signature **Date**