Heimer Eye Care Associates, P.C.

Patient Information Date: __________

Patient's Name
(Mr./Ms./Mrs./Miss) ____
First MI Last

Street Address ____

____
City State Zip Code

Home # ______________________ Cell # _____________________ Work # __________________

Email _____________________________ Date of Birth ________________________ Age _____

Family Physician ________________________ Referring Physician________________________

Local Pharmacy _________________________ Mail Order Pharmacy ______________________

Emergency Contact ____ Phone ______________

Race: ☐ White ☐ Asian ☐ Black/African American ☐ Spanish/Hispanic Origin
☐ American Indian ☐ Native Hawaiiian/Other Pacific Islander ☐ Other
☐ Patient Decline/Unknown
Gender: ☐ Male ☐ Female Preferred Language: ___________________________________

Is patient enrolled in Hospice? ☐ YES ☐ NO ; If yes, Medicare ID#_____________________

Primary Medical Insurance: ____

Subscriber: _____________________________________ DOB: ______________________

ID: ____ Group #: __________________

Secondary Medical Insurance: ____

Subscriber: _____________________________________ DOB: ______________________

ID: ____ Group #: __________________

If seen by us for a worker's compensation injury:
Company: ____
HR contact: ____ Phone # ______________