

Patient Last Name	Patient First Name	MI	Date of Birth	SEX <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other: _____
Social Security #	Email Address		Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W	
Employment Status: <input type="checkbox"/> Employed <input type="checkbox"/> Retired <input type="checkbox"/> Self-Employed <input type="checkbox"/> Part-Time Student <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Disabled <input type="checkbox"/> Unemployed				

**The Federal Government asks providers to ask the questions below.**

Race <input type="checkbox"/> Caucasian <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Native Indian / Native Alaskan <input type="checkbox"/> Native Hawaiian / Pacific Islander <input type="checkbox"/> Other Race <input type="checkbox"/> Unknown	Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Caucasian <input type="checkbox"/> Other <input type="checkbox"/> Unknown	Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> Polish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Sign <input type="checkbox"/> Other
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Home Address	City	State	Zip Code
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Billing / Mailing Address	City	State	Zip Code
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Preferred Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	Additional Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	Additional Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
Leave detailed message?: <input type="checkbox"/> Yes <input type="checkbox"/> No	Leave detailed message?: <input type="checkbox"/> Yes <input type="checkbox"/> No	Leave detailed message?: <input type="checkbox"/> Yes <input type="checkbox"/> No

Employer	Employer Address	City	State	Zip Code
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<b>Primary Care Provider:</b>	<b>Referring Physician:</b>	<b>Ophthalmologist:</b>
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Primary Insurance Coverage Name	Insurance ID #: _____ Group #: _____	Effective Date: _____
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Subscriber: <input type="checkbox"/> Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other Subscriber Name:	Date of Birth: _____ Social Security #: _____	Employer:
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Secondary Insurance Coverage Name	Insurance ID #: _____ Group #: _____	Effective Date: _____ Copoly \$: _____ Deductible: _____
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Subscriber: <input type="checkbox"/> Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other Subscriber Name:	Date of Birth: _____ Social Security #: _____	Employer:
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Emergency Contact	Relationship to Patient: <input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Friend <input type="checkbox"/> Guardian <input type="checkbox"/> Other		
	Name: _____	Contact Phone: _____	Work Phone: _____

I hereby authorize direct payment to medical/surgical benefits to Prime Healthcare, PC for services rendered by our providers. I understand that I am financially responsible for any balance not covered by my insurance. I certify that the information given by me above is correct. I hereby authorize Prime Healthcare, PC, its agents and representatives, to access information regarding my person, whereabouts, and to release all necessary information to my insurance company regarding my medical history, examinations, and treatments for the purposes of processing my insurance claims. A photocopy of my signature is valid as the original.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PARENT / GUARDIAN INFORMATION**

Relationship to Patient:  Parent  Guardian  Brother/Sister  Power of Attorney  Other

Name:	Social Security #:	Date of Birth:	Contact #:
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<b>PHARMACY NAME/ADDRESS:</b>	<b>Phone Number:</b>
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