SPRINGFIELD EYE ASSOCIATES, INC.

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PLEASE PRINT ALL INFORMATION and please have your Insurance Card(s) ready to be scanned.

Today's Date _____ Primary Care Physician _____

Last Name: _____ First Name _____ M.I._____

Street Address: _____

City: _____ State :_____ Zip _____

Home Phone (____)_____ Cell Phone (_____)_____ Work Phone _____

DOB: _____/ _____/_____ Social Security Number _____/_____/_____

Sex: M F Marital Status: Single , Married, Widow, Divorced

E-Mail address _____ Preferred language _____

Race: (Circle one) American Indian or Alaskan Indian, Asian, Black or African American, Native Hawaiian or Pacific Islander, Refuse to Report/Unreported, or White/Caucasian

Ethnicity: (Circle one) Hispanic or Latino, Non Hispanic or Latino, Refuse to Report/Unreported

Name of Contact Person in Case of Emergency:

Name: _____Phone (____)_____ Relationship _____

Preferred Pharmacy:

Name: _____ Address: _____ City _____

Work History:
Employer if still working:_____ Occupation _____

Are you Retired : Yes No

Person Responsible for bill if NOT the patient

Name _____ DOB_____ Relationship _____

Address _____City_____ State_____ Zip_____

IF Workers Compensation: Injury Date_____ Reported to employer: YES NO

Employer: _____ Address: _____

City_____ State_____ Zip_____