DRUMMOND EYE CLINIC PATIENT DEMOGRAPHIC SHEET

NAME____ TODAY'S DATE________________

ADDRESS____
(Address) (City, State, Zip)

IF A STUDENT PLEASE LIST YOUR PERMANENT MAILING ADDRESS SOCIAL SECURITY #________________________

PERSONAL PHYSICIAN______________________ PREFERRED PHARMACY__________________________

SEX M____F____ DATE OF BIRTH__________________ MARITAL STATUS__________________

HOME PHONE___________________ WORK PHONE_________________ CELL PHONE__________________

EMAIL ADDRESS____RACE______________________

WHAT IS YOUR PREFERRED METHOD OF COMMUNICATION? ☐MAIL ☐PHONE (WHICH #)___________

EMPLOYER_____________________________________ OCCUPATION___________________________

IF PATIENT IS A CHILD OR STUDENT, PLEASE FILL IN AS PARENT'S INFORMATION

SPOUSE'S NAME_____________________________ SPOUSE'S BIRTHDATE_____________________

SPOUSE'S SOCIAL SECURITY #______________________ SPOUSE'S EMPLOYER________________________

SPOUSE'S WORK #_____________________________ SPOUSE'S CELL # __________________________

IF PATIENT IS NOT THE INSURED MEMBER PLEASE COMPLETE THIS SECTION

INSURED MEMBER'S NAME_________________________ INSURED MEMBER'S BIRTHDATE___________________

INSURED MEMBER'S SOCIAL SECURITY #______________________ INSURED MEMBER EMPLOYER_________________________

EMERGENCY CONTACT PERSON OUTSIDE OF HOME

NAME_______________________________ **RELATIONSHIP TO PATIENT**___________________

DAYTIME PHONE____________________ ALTERNATE #____

SIGNATURE ON FILE

I authorize use of this form on all my insurance submissions. I authorize release of information to all my insurance companies. I understand that **I AM RESPONSIBLE** for my bill. I authorize payment direct to my doctor and I permit a copy of this authorization to be used in place of the original.

In the matter of divorced families, the person accompanying the patient is responsible for the bill. We are unable to be involved in these matters, and will be happy to provide a copy of the receipt.

SIGNATURE____ DATE_________________________