McElhinney Eye Care, PA

PATIENT INFORMATION

DEMOGRAPHICS

NAME LAST FIRST MI			BIRTHDATE	AGE	SEX
STREET ADDRESS			SOCIAL SECURITY #		
CITY	STATE	ZIP CODE	SPECIAL NEEDS (choose one) ☐ WHEEL CHAIR ☐ WALKER ☐ HEARING IMPAIRED		
PRIMARY PHONE ( ) ☐ CELL ☐ HOME ☐ WORK	ALTERNATE PHONE ( ) ☐ CELL ☐ HOME ☐ WORK	EMAIL ADDRESS	☐ AMERICAN INDIAN/ALASKA ☐ ASIAN ☐ WHITE ☐ AFRICAN AMERICAN ☐ HAWAIIAN PACIFIC ISLANDER		HISPANIC/ LATINO ☐ YES ☐ NO
EMPLOYER/NAME ADDRESS	POSITION/DEPARTMENT		MARITAL STATUS (choose one) ☐ MARRIED ☐ DIVORCED ☐ SINGLE ☐ WIDOWED		
SPOUSE			SPOUSE PHONE		
EMERGENCY CONTACT			EMERGENCY PHONE		

BILLING

GUARANTOR (FINANCIALLY RESPONSIBLE PERSON)			RELATIONSHIP TO PATIENT (CIRCLE) ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER	
STREET ADDRESS			PHONE ( )	
CITY			STATE	ZIP CODE
PRIMARY INSURANCE	POLICY HOLDER	POLICY ID#	GROUP #	INSURED'S DOB
SECONDARY INSURANCE	POLICY HOLDER	POLICY ID#	GROUP #	INSURED'S DOB
ARE YOU UNDER THE CARE OF A SKILLED NURSING FACILITY? YES NO		IF YES, PLEASE LIST NAME, ADDRESS AND PHONE NUMBER.		