Demographic Information

Male or Female (Please circle one) Mr. Miss Ms. Mrs. Today's Date _____/_____/_____

Name: _____ Age: _____

Address: _____ City:_____ _____ST:_____ Zip Code:_____

Birth Date: _____/_____/_____ Social Security #:_____-_____-_____

Home Phone: _____ Cell: _____ Email: _____

How would you like to be contacted? Please select all that apply: [ ] Phone [ ] Text [ ] Emailed

Employer: _____

Spouse or Emergency Contact: _____ Spouse's Employer:_____

Parents / Legal Guardian (if patient is minor child):

Father: _____ Mother: _____ Legal Guardian: _____

Insurance Information

Name of Medical Insurance: _____Policy #_____

Name of Vision Insurance: _____ Policy #:_____

Name of Policy Holder_____ Policy Holder's Birth Date: _____/_____/_____

Policy Holder's Social Security #:_____-_____-_____

Acknowledgement of Notice of Privacy Practices

The law requires that Hill Family Eye Center, Inc. make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that I have read, had explained to me, or was given the opportunity to read Hill Family Eye Center, Inc.'s Notice of Privacy Practice and agree to continue my care with Hill Family Eye Center, Inc. under said terms.

The following persons may obtain information regarding this patient and may bring this patient for any appointments:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

Signature: _____**Date**:_____

If you are signing as a personal representative of the patient, please indicate your relationship.

Representative: _____ Relationship to Patient: _____