Kenton Family Eye Care, Inc. Patient Information Sheet

Patient Name ____ Today's Date ____________________

Other Name/Nickname if preferred ____

Address ____

City ____ State ________________ Zip ________________

Home Phone ________________________________ Daytime Phone _______________________________

Cell Phone ____________________________ Texts? Y ☐ N ☐ Email ____________________________________

Date of Birth _________________________ Sex: M ☐ F ☐ SSN __________________________________

Marital Status ☐ Single ☐ Married ☐ Other Spouse's Name ____________________________________

If patient is a minor: Father's name ____
Mother's Name ____

Race *(Select One)* ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian ☐ Other Pacific Islander ☐ White (Caucasian)

Ethnicity *(Select One)* ☐ Hispanic or Latino ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Not Hispanic

Preferred Language ☐ English ☐ Spanish ☐ Other ______________________________

Employment Status: ☐ Employed ☐ Full Time Student ☐ Part Time Student ☐ None

Employer _______________________________________ Occupation __________________________________

Primary Care Physician _____________________________________ Physician's Phone _____________________

Physician's Address ____

Who may we thank for referring you to our office?

☐ Current Patient ____________________________ ☐ Member of the Family ____________________________
☐ Yellow Pages ☐ Word of Mouth ☐ Advertising
☐ Another Doctor ____________________________ ☐ Other

Insurance Information

Vision/Eyeglass Insurance ____

Subscriber's Name __________________________________ Relationship to Patient ________________________

Major Medical Insurance ____

Subscriber's Name __________________________________ Relationship to Patient ________________________