Peninsula Eye Physicians

Welcome to Our Practice!

Patient Name: _____ **DOB:** _____/_____/_____ **Sex**: ☐ Male ☐ Female

Marital Status: ☐ S ☐ M ☐ W ☐ D ☐ DP **Social Security – Last 4** #: _____ **License #**: _____

Parents' Name (If minor): _____ **E-Mail**:_____

Home Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Work#: _____

Emergency Contact: _____ **Relationship:** _____ Phone #:_____

Primary Care Physician: _____ **Referred By**: _____

Insurance Information:

Primary Ins: _____ Subscriber: ☐ Self **or** ☐ Other, Name: _____

*If Other, Subscriber DOB: _____ Relationship to Subscriber: ☐ Spouse ☐ Child ☐ Other

Secondary Ins: _____ Subscriber: ☐ Self **or** ☐ Other, Name: _____

*If Other, Subscriber DOB: _____ Relationship to Subscriber: ☐ Spouse ☐ Child ☐ Other

Tertiary Ins: _____ Subscriber: ☐ Self **or** ☐ Other, Name: _____

*If Other, Subscriber DOB: _____ Relationship to Subscriber: ☐ Spouse ☐ Child ☐ Other

Vision Service Plan (VSP): ☐ Self **or** ☐ Other, Name: _____

*If Other, Subscriber DOB: _____ Relationship to Subscriber: ☐ Spouse ☐ Child ☐ Other

Health Information Portability and Accountability Act (HIPAA):

Acknowledgement of receipt of Notice: I hereby acknowledge that I have received/or have been offered a copy of Peninsula Eye Physicians Notice of Privacy Practices. _____ (Initial)

_____	_____	_____
Print Name	**Signature**	**Date**

If not signed by the patient, please indicate your relationship to the patient: _____

☐ Parent or guardian of minor patient ☐ Guardian or conservator of an incompetent patient,

Updated: _____ _____

Initial and Date Initial and Date