**PATIENT INFORMATION SHEET**

**Today's Date: _____**

**Patient's Name: LAST: _____ FIRST: _____ MI: _____**

**SSN: _____-____-_____ Date of Birth: _____ Age: _____ Male: _____ Female: _____**

**___Single ____Married ____Widowed ____Divorced E-Mail Address: _____**

**Address: _____ City: _____ ST: _____ Zip: _____**

**Phone: Home: (____)_____ Work: (____)_____ Other: (____)_____**

**Employer's Name: _____ Phone: (____)_____**

**Primary Policyholder:**
**Insurance Co.: _____ Yourself: _____ Spouse: _____ Parent: _____**

**Name of Primary Policyholder: _____ SSN: _____-____-_____ DOB: _____**

**Name of Spouse: _____ Employer: _____ Ph: (____)_____**

**If patient is a MINOR, Name of Responsible Parent:**

**_____**
**(Please fill in employment information for responsible parent above)**
**_____**

***Person Responsible for Payment if Other than Above:* *Name:* _____**

***Address:* _____ *Phone:* (____)_____ *Relationship:* _____**

**Please check and/or complete the following:**

**How did you choose /or/ were referred to Cobb Eye Center for your eye care?**

**____ Primary Care Physician _____**
**Name**

**____ Emergency Room /or/ Hospital (Inpatient or Discharged Patient)**

**____ Insurance Book**

**____ Family / Friends**

**____ Yellow Pages / Phone Book**

**____ Internet / Website**

**____ Other _____**

**_____**

***Please inform receptionist if you DO NOT want appointment reminders by phone and/or mail.***