EYE care ASSOCIATES
OF CHARLOTTE, P.L.L.C.

New Patient Information

Please fill out completely

Legal Name: _____ Preferred Name: _____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Gender: ☐ male ☐ female

Home Phone: _____ Cell Phone: _____

How would you like us to contact you? ☐ Cell ☐ Text ☐ Email ☐ Home phone ☐ Mail

Is it ok to text you? ☐ Yes ☐ No May we leave detailed voicemails? (may not remain private) ☐ Yes ☐ No

Social Security #: _____

Employer: _____ Occupation: _____

Work Phone: _____ May we contact you at this number? ☐ Yes ☐ No

Are you: ☐ Full-time ☐ Part-time ☐ Retired ☐ Student ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Race:
☐ American Indian/Alaskan Native
☐ Asian
☐ Black
☐ Hispanic
☐ White
☐ Decline to Specify

Ethnicity:
☐ Hispanic or Latino
☐ Native Hawaiian/other Pac Islander
☐ Not Hispanic or Latino
☐ Decline to Specify

Preferred Language:
☐ English
☐ Spanish
☐ French
☐ Japanese
☐ Other
☐ Decline to Specify

If Patient is under 18 years of age, please provide information for person responsible for account:

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Who is your primary care physician?

Name: _____ Phone: _____

Address: _____

Please complete information on other side of page

INSURANCE INFO: Please provide all insurance cards & a photo ID so we may scan them into your record

Primary Vision: _____ Policy #: _____

Relationship to policy holder: ☐ Self ☐ Spouse ☐ Child If not self, please fill out below information

Policy Holder Name: _____ Date of Birth: _____

Policy Holder Address: _____

Policy Holder Employer: _____ Gender ☐ M ☐ F

Secondary Vision: _____ Policy #: _____

Relationship to policy holder: ☐ Self ☐ Spouse ☐ Child If not self, please fill out below information

Policy Holder Name: _____ Date of Birth: _____

Policy Holder Address: _____

Policy Holder Employer: _____ Gender ☐ M ☐ F

Primary Medical: _____ Policy #: _____

Relationship to policy holder: ☐ Self ☐ Spouse ☐ Child If not self, please fill out below information

Policy Holder Name: _____ Date of Birth: _____

Policy Holder Address: _____

Policy Holder Employer: _____ Gender ☐ M ☐ F

Secondary Medical: _____ Policy #: _____

Relationship to policy holder: ☐ Self ☐ Spouse ☐ Child If not self, please fill out below information

Policy Holder Name: _____ Date of Birth: _____

Policy Holder Address: _____

Policy Holder Employer: _____ Gender ☐ M ☐ F

Emergency Contact: _____ Phone:_____

Please list any person(s) that you may wish us to speak with in regards to your care and/or account:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Information is complete and correct to the best of my knowledge:

_____ _____

Patient / Guardian Signature Date