EYE CARE CENTER
OF NEWTON

Patient Information Form

Today's Date: _____

Last Name: _____ First Name: _____ MI: _____

Address: _____ Preferred Name: _____

City: _____ State: _____ Zip: _____

Primary Phone: (___) _____ Other: (___) _____

Email: _____ Social Sec. #: _____

Birthdate: ____ / ____ / ____ Male: ____ Female: ____

Ethnicity: ____ Hispanic or Latino ____ Non-Hispanic or Latino

Race: __White __African American __Alaskan Indian __American Indian __Asian __Pacific Islander __Other

Preferred Language: ____ English ____Spanish ____Other _____

Place of Employment: _____ Occupation: _____

Spouse/Partner's Name: _____ Work Phone #: (___)_____

If a minor – Father's Name: _____ Mother's Name: _____

And/or Legal Guardian: _____

Primary Care Provider: _____ Last Health Physical: _____

Pharmacy: _____

Health Information Release Consent

I hereby give consent to the Eye Care Center of Newton to communicate to me any health information via the following methods (please check all that apply):

___Voicemail or Answering Machine ___Home Phone ___Cell ___Work Phone

___Email (as above) ___ Text

Please Fill out the following if you would like us to be able to discuss your health information with others (list up to two – if patient is a minor, health information will be shared with both parents unless otherwise stated)

Name: _____ Relationship: _____ Phone Number: _____

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How Did You Hear About us?

__Word of Mouth __Social Media __TV __Radio __ Newspaper __Google Search __Insurance Plan