BUTTE FAMILY EYE CENTER

PATIENT INFORMATION

Patient's Name: _____ Date of Birth: _____

Social Security #: _____ Sex: [ ]M [ ]F Marital Status: [ ] Married [ ] Single [ ]Divorced [ ] Widowed

Mailing Address: _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Ok to contact by e-mail: [ ]Yes [ ]No If so, e-mail address: _____

Occupation: _____ Employer: _____ Phone : _____

Primary Care Physician: _____ Height: _____ Weight: _____

Race: [ ] American Indian or Alaska Native [ ] Asian [ ] Black or African American [ ] Native Hawaiian or Other Pacific Native [ ] White [ ] Opt Out

Ethnicity: [ ] Hispanic or Latino [ ] Not Hispanic or Latino [ ] Opt Out

Preferred Language: [ ] English [ ] Spanish [ ] Other:_____

EMERGENCY CONTACT

Name: _____ Phone: _____

Relationship: _____

RESPONSIBLE PARTY INFORMATION *Adult accompanying minor (17 years of age or under) is responsible party*

Responsible Party: _____ Patient Relationship: _____

Date of Birth: _____ Social Security #: _____

Address: _____ City, State, Zip: _____

Phone: _____ Phone: _____

I authorize treatment of the person named above. I certify that I am the patient or the legal guardian of the patient.

_____ _____

Signature of **Patient** or Legal Guardian (if patient is a minor) Date