Omaha Center for Sight

Patient Information

Please use black ink only

Name: _____ Social Security #:_____

Address: _____ DOB: _____

City: _____ State: _____ Zip Code: _____

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

Which phone is your preferred method of Contact? ☐ Home ☐ Work ☐ Cell

Email: _____

Employer: _____ Employer Phone: _____

Primary Care Doctor: _____ Referring: _____

Race: ☐ Caucasian ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native
☐ Native Hawaiian/Pacific Islander ☐ Other

Primary Language: _____

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Unknown

Insurance Holder (if different from patient)

Name: _____ DOB: _____ Social Security: _____

Relationship: _____ Employer: _____

Address: _____ Phone: _____

City, State, Zip: _____

Primary Insurance

Policy Holder: _____

Insurance Co: _____

Policy ID: _____

Group #:_____

Secondary Insurance

Policy Holder: _____

Insurance Co: _____

Policy ID: _____

Group #: _____

Emergency Contacts & Permission to Release Medical information

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Patient knowledges that the above information is correct to the best of their knowledge.

Patient Signature: _____ Date: _____