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 primary method of contact? ☐ Home ☐ Work ☐ Cell

Which is your preferred method for reminder calls? ☐ Voice Message ☐ Text Message ☐ Email

Ok to leave voicemail? ☐ Yes ☐ No

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: _____

Secondary Insurance

Policy Holder: _____

Insurance Co: _____

Policy ID: _____

Emergency Contact(s) & 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 or Responsible Party Signature: _____ Date: _____

Name and Relationship of Responsible Party: _____