CREEKSIDE
VISION & HEARING

NEW PATIENT INFORMATION

Date: _____

PLEASE USE BLUE OR BLACK INK ONLY

Patient Name: _____ Birth Date:_____
(First) (Middle Initial) (Last)

Address: _____
(Street) (City) (State) (Zip)

Home Phone#: _____ Social Security#: _____

Cell Phone#: _____ Work Phone#: _____

Preferred Phone# for Reminder Calls (circle one): Home Cell

E-mail Address: _____

Family Doctor: _____

☐ Male ☐ Female ☐ Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Race: ☐ African American ☐ Asian ☐ Native American ☐ White

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Employment Information:

Employer:_____

☐ Full-Time ☐ Part-Time ☐ Retired

Employer Address:_____
(Street) (City) (State) (Zip)

If Self-Employed, type of business:_____

Spouse Information:

Spouse Name:_____ Birth Date:_____

Social Security#:_____ Cell Phone#:_____

Employer: _____

☐ Full-Time ☐ Part-Time ☐ Retired Work Phone#:_____

Emergency Information:

Emergency Contact Name:_____

Phone #:_____ Relationship: _____

IF PATIENT IS A MINOR CHILD, COMPLETE THE FOLLOWING INFORMATION:

Father's Name:_____	Mother's Name:_____
Birth Date:_____	Birth Date: _____
Social Security#:_____	Social Security#:_____
Address:_____	Address:_____
_____	_____
Home Phone:_____	Home Phone:_____
Employer:_____	Employer:_____
Work Phone:_____	Work Phone:_____
E-mail:_____	E-mail:_____

PLEASE CONTINUE ON REVERSE

CREEKSIDE
VISION & HEARING

INSURANCE INFORMATION

1st Insurance Company

Name:_____
Subscriber:_____
Employer:_____
Subscriber #:_____
Group #:_____

2nd Insurance Company

Name:_____
Subscriber:_____
Employer:_____
Subscriber #:_____
Group #:_____

3rd Insurance Company

Name:_____
Subscriber:_____
Employer:_____
Subscriber #:_____
Group #:_____

Vision Insurance Company

Name:_____
Subscriber:_____
Employer:_____
Subscriber #:_____
Group #:_____

Hearing Insurance Company

Name:_____
Subscriber:_____
Employer:_____
Subscriber #:_____
Group #:_____