Bluegrass Family Eyecare
Patient Demographics

Patient Information

Patient Name: DOB:

Patient Address:

City: State: Zip:

Patient Cell Phone: Patient Home Phone:

Patient Work Phone: Gender:

Patient SSN: Employer:

Email Address:

What is your preferred method of communication for appointment reminders and recalls?

☐Email ☐Phone-Cell ☐Phone-Home ☐Phone-Work ☐Text ☐Mail

Ethnicity:

☐Not Hispanic or Latino ☐Hispanic or Latino

Race:

☐American Indian or Alaskan Native ☐Asian ☐Black or African American

☐Native Hawaiian or Other Pacific Islander ☐White

Person Responsible for Payment

Name: DOB:

Address:

City: State: Zip:

Cell Phone: Patient Home Phone:

Work Phone:

Insurance Information

Type of Insurance:

Subscriber Name: Subscriber DOB:

Relationship to Subscriber: Subscriber SSN:

Individuals Involved in Care

The following individual(s) and/or doctors are involved in my care and may be given medical and/or financial information related to my treatment:

Name: Phone:

Name: Phone:

Notice of Privacy Practices

I acknowledge, by my signature below that I have been given the opportunity to review the Notice of Privacy Practices for Bluegrass Family Eyecare and I understand that I may request a copy of the notice should I so choose. I agree to electronic communication of appointment reminders as indicated above and outlined in the Notice of Privacy Practices.

Patient or Parent/Guardian Signature **Date**