HEATON
EYE ASSOCIATES
Come See The Difference

PATIENT INFORMATION

Last Name:		First Name:		Middle Initial:
DOB:	Age:	SS#:	☐ Male ☐ Female	
Email:		Home Phone:	Cell Phone:	
Marital Status *(circle one)*: Single / Married / Divorced / Separated / Widow				
Address:		City:	State:	Zip:
Employer:		Job Title/Occupation:	Phone:	
Address:		City:	State:	Zip:
☐ Retired – When and where?				
Spouse:		Home Phone:	Cell Phone:	
Address:		City:	State:	Zip:
DOB:	SS#:	☐ Male ☐ Female		
Email:		Home Phone:	Cell Phone:	
Employer:		Job Title/Occupation:	Phone:	
Address:		City:	State:	Zip:
☐ Retired – When and where?				
Emergency Contact & Phone *(friend/relative living at different address)*:				
Primary Insurance:				
Policy Holder:		Policy Number:		
Other Insurance:				
Policy Holder:		Policy Number:		
Here for a workers' compensation injury? ☐ No ☐ Yes		Date of Injury:		
Contact Person at Work & Work Phone:				
I declare I have no other insurance than what is listed *(sign & date)*				
Race/Ethnicity: ☐ Hispanic/Latino ☐ American Indian/Alaskan ☐ Asian ☐ Black/African American ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other *(please list)*:				
Preferred Language: ☐ English ☐ Other *(please list)*:				
Referring Optometrist:		Primary Care Physician (PCP):		
I am interested in learning more about: ☐ LASIK ☐ Getting Out of Glasses ☐ Cosmetic Procedures and/or BOTOX				

PLEASE BRING YOUR INSURANCE CARDS AND DRIVER'S LICENSE TO THE FRONT DESK.