EYE CENTER of MIDLAND

2706 W. Cuthbert Ave., Building A Midland, TX 79701 (432) 694-0999

DATE: ______________________

NAME: __________________________________ AGE: ________ DATE OF BIRTH: _________________

ADDRESS: ____________________________ CITY: _______________ STATE: ______ ZIP: __________

HOME PHONE: ____________________ CELL: ___________________ EMAIL: ____________________

SEX: ❑ M ❑ F PATIENT SS #: _________________________________

MARITAL STATUS: ❑ Single ❑ Married ❑ Divorced ❑Widowed

RESPONSIBLE PARTY: ___________________________________ PHONE: _______________________
(SELF, SPOUSE, PARENT)

IS THE PATIENT IN A SKILLED NURSING FACILITY: ❑ YES ❑ NO

EMERGENCY CONTACT: ____________________RELATION: ______________PHONE:___________

REFERRED BY: ____

PHARMACY: ____PHONE: ___________________________

RACE: _________________ETHNICITY: ____________________LANGUAGE: __________________

PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING:

❑ CATARACTS ❑ HIGH BLOOD PRESSURE ❑ CANCER ❑ CROSSED EYES ❑ GLAUCOMA
❑ RETINAL DISEASE ❑ HEART DISEASE ❑ DIABETES ❑ THYROID DISEASE
❑ SMOKER ❑ PREVIOUSE EYE SURGERIES: ____

PLEASE CHECK IF ANY FAMILY MEMBER HAS EVER HAD THE FOLLOWING:

PLEASE SPECIFY: M-MOTHER, F-FATHER, B-BROTHER, S-SISTER
❑ CATARACTS____❑ HIGH BLOOD PRESSURE____❑ CANCER____❑ CROSSED EYES____❑ GLAUCOMA____❑ DIABETES____

LIST ANY MEDICATIONS YOU ARE TAKING: ____
____

LIST ANY MEDICATIONS YOU ARE ALLERGIC TO: _______________________________________

NAME OF FAMILY PHYSICIAN: ____________________________PHONE: ______________________

PRMIARY INSURANCE: ______________________ SECONDARY INSURANCE: __________________

PLEASE PROVIDE THE INSURED NAME/DOB/SS #: ____
____

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED. THANK YOU!