HIGH DESERT
INSTITUTE OF
OPHTHALMOLOGY

Patient Demographic Form

PATIENT INFORMATION

Medication Allergies: **No** ☐ ☐ **Yes**______________________

First Name **Last Name** **Middle Initial** **DOB**

____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic, Latino or Spanish ☐ Native Hawaiian or other Pacific Islands ☐ Middle Eastern or North African ☐ White ☐ Declined to specify

____

Ethnicity ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Declined to specify **Gender** ☐ Male ☐ Female

____

Home Address **Apt #** **City** **State** **Zip Code**

____

Driver's License # **Social Security #** **Home/Cell #** **Employer** **Employer Phone #**

____

Personal Email Address **Primary Spoken Language:** ☐ **English** ☐ **Spanish**

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SPOUSE, PARENT, OR GAURDIAN INFORMATION

First Name **Last Name** **Relationship to Patient** ☐ **Spouse** ☐ **Parent** ☐ **Guardian**

____

Home # **Cell #** **Share Medical Info with this person?** ☐ **Yes** ☐ **No**

____

EMERGENCY CONTACT INFORMATION

First Name **Last Name** **Home/Cell #** **Share medical info with this person?** ☐ **Yes** ☐ **No**

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PRIMARY CARE PHYSICIAN (PCP) INFORMATION

Primary Care Physician Name **Phone #** **Medical Group Name**

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Subscriber First Name Subscriber **Last Name** **Date of Birth** **Relation to Patient**
☐ **Self** ☐ **Spouse** ☐ **Child**

____

PREFERRED PHARMACY

Pharmacy Name **Pharmacy Address** **Pharmacy #**

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I understand that I need to present my insurance card and a form of identification at my visits with High Desert Institute of Ophthalmology. It is my responsibility to notify the office staff regarding any insurance changes. **_____(INITIAL)**

I have been aware and have been offered a paper copy of **The Notice of Privacy Practices** **_____(INITIAL)**

Assignment of Benefits: I hereby assign medical and/or surgical benefits, to which I am entitled, including Medicare, private insurance, POS and any other health and/or vision plan to: **High Desert Institute of Ophthalmology Inc**. – The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as original. I hereby authorize said assignee to release all information necessary to secure the payment. **_____(INITIAL)**

I understand that **I am financially responsible for all uncovered services that my insurance determines is my responsibility** (Deductibles, Co-insurance, Copays, etc.) **_____(INITIAL)**

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Patient's Signature/Legal Guardian **Date**