KIRK
EYE CENTER

PLEASE LET US KNOW HOW YOU HEARD ABOUT OUR OFFICE
☐ Internet/Google ☐ Sign on Building/Drove By ☐ Other
☐ Friend/Family Member: _____
☐ Doctor/Optometrist: _____

Patient Information

Last _____First _____ MI _____ Date _____

Address _____ SSN Last 4 Digits _____

City _____ State _____ Zip _____ Birth Date _____

Home Phone _____ Cell _____ Work _____

Email _____

Preferred Phone: Home Cell Work

Race: ☐ Asian ☐ Black/African American ☐ White ☐ American Indian/Alaska Native
☐ Decline to Specify ☐ Other _____

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Decline to Specify

Language: ☐ English ☐ Spanish ☐ Other _____

Emergency Contact _____ Phone _____

Relationship to Patient _____

Primary Insurance (subscriber)

Subscriber Name _____ Relationship _____

Subscriber Address _____ Birth Date _____

Secondary Insurance (subscriber)

Subscriber Name _____ Relationship _____

Subscriber Address _____ Birth Date _____

Employer _____

Address _____ City _____ State _____ Zip _____

Primary Care Doctor _____ Phone _____

Address _____ City _____ State _____ Zip _____

I have received a copy of the Notice of Privacy Practices _____ (initial here)