# Carolina Ophthalmology - Patient Information Sheet

## Demographic Information

Today's Date: ____/____/_____ Date Of Birth ____/____/_____ Sex: ☐ Male ☐ Female

Name _____ SS# _____-_____-_____
Last First MI

Mailing Address _____
Street City State Zip Code

Home Phone _____ Cell Phone _____ Work Phone _____

E-mail address _____ May we contact you at this email? ☐ yes ☐ no

Employer _____
Name Address

Responsible Party/POA _____
Name Address and Phone# Relation

*If patient is under 18 years old *Responsible Party SS# _____-_____-_____ Responsible Party DOB _____/_____/_____

**(*** If POA (Power of Attorney) please present documents so they may be copied for the patient's chart.)**

Emergency Contact _____
Name Address and Phone# Relation

Is this your first visit to our office? Y N If yes, referred by _____

## Insurance Information

***** Please present insurance card(s) and a photo ID to be scanned for your chart. *****

**Primary** Insurance Company _____ Policy Holder SS# _____-_____-_____

Policy Holder Name _____ /____/____
Last First MI Relation to patient DOB

**Secondary** Insurance Company _____ Policy Holder SS# _____-_____-_____

Policy Holder Name _____ /____/____
Last First MI Relation to patient DOB

For Office Use Only:
Verified Demographics/Insurance in Allscripts: _____

**Form 31, Revised 03/04/2013**