☐ **ASSOCIATED EYE CARE**
11960 LIONESS WAY
SUITE 190
PARKER, CO 80134

☐ **ASSOCIATED EYE CARE**
8101 E LOWRY BLVD
SUITE 255
DENVER, CO 80230

ASSOCIATED EYECARE

PATIENT INFORMATION

Please verify the following information, make necessary changes, and supply any missing information.

Today's Date: ____/_____/_____

Patient Information

Date of Birth: _____/_____/_____ Age: ____ Sex: _____

Patient Name (First, Middle, Last): _____

Preferred Name: _____

Suffix (Jr., Sr.): _____ Salutation (Mr., Mrs.): _____ Primary Language: _____

Address (Street, City, State, Zip): _____

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Email Address: _____

SSN: _____ - _____ - _____

Special Needs (Wheelchair, Translator Hearing Impaired): _____

Primary Eye Doctor: _____

Primary Care Physician: _____

Primary Care Physician Phone: (_____) _____ - _____

Other Specialist Eye Doctors: _____

Other Specialist Phone: _____

Parent/Legal Guardian (If patient is under 18) / Account Responsible:

Patient's Relationship to the Responsible Party (Self, Spouse, Child): _____

Responsible Party's Name (Salutation, First, Middle, Last): _____

Date of Birth: _____/_____/_____ Gender: _____

Home Phone: (_____) _____ - _____

Cell Phone: (_____) _____ - _____ Work Phone / Ext: _____

Address (Street, City, State, Zip): _____

Email Address: _____

Social Security#: _____ - _____ - _____

Primary Insurance:	**Secondary Insurance:**
Insured's Name	Insured's Name
Insurance Company Name	Insurance Company Name

Emergency Contacts:

Name / Relationship	Emergency Contact (Circle One)	Release of Medical Information (Circle One)	Phone
	YES / NO	YES / NO	
	YES / NO	YES / NO	

Signature: _____ **Date:** _____/_____/_____