BESSEMER
FAMILY EYE CARE

PATIENT INFORMATION

Dr. _____ Mr. _____ Mrs. _____ Ms. _____ Miss _____ Male/Female? _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ □ Mobile □ Home □ Work

Email Address: _____

Communication Preference: □ Email □ Mail □ Phone

May we email or text you important messages? □ Yes □ No

Date of Birth: _____ Social Security #: _____

Place of Employment/School: _____ Occupation: _____

Spouse/Parent Name: _____

Spouse/Parent Phone #: _____

Demographic Information Requested by Federal Government

Race: □ American Indian or Alaska Native □ Asian □ Black or African American
□ Native Hawaiian or Pacific Islander □ White or Caucasian

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino

Preferred Language: □ English □ Spanish □ Other _____

Responsible Party Information

Person Responsible for Bill _____

Address: _____ Phone: _____

Medical Insurance: _____ Policy #:_____

Vision Insurance: _____ Policy #:_____

If the insured is other than patient, please provide the following:

Insured's Social Security #:_____ Date of Birth: _____

Insured's Employer: _____

Other Insurance Information: _____

Do you currently wear glasses?	Yes	No
Do you plan to update your glasses?	Yes	No
Do you currently wear contacts?	Yes	No
*Do you have backup glasses?	Yes	No
Do you have prescription sunglasses?	Yes	No
Are you interested in thinner lenses?	Yes	No
Are you interested in LASIK?	Yes	No
Do you work on a computer?	Yes	No

NEW PATIENTS ONLY:

Who may we thank for referring you to us?

_____

If not referred, how did you choose us?

_____