CENTURY
EYE CARE

Patient Information **Date**

Last Name _____ First Name _____ Middle Initial_____
Nickname/AKA _____ Date of Birth_____ SSN#_____
Gender [ ] M [ ] F [ ]Other Marital Status _____ Ethnicity [ ] American Indian or Alaska Native [ ] Asian
Email Address _____ [ ] Black or African American [ ] Hispanic or Latino
Home Phone _____ [ ] Native Hawaiian or Pacific [ ] White or Caucasian
Cell Phone _____ [ ] Decline to specify

Mailing Address _____ Apt # _____ City _____ State _____
Zip Code _____
Home Phone _____ Cell Phone _____
Email Address _____
Employment Status [ ] Active Duty [ ] Not Employed [ ] Child Primary Care Provider:
[ ]Employed **FT** [ ] Retired [ ] Other _____
[ ]Employed **PT** [ ] Student [ ] Self Employed

Occupation _____ Employer _____

Insurance

Member ID #_____ Group # _____ Subscriber's Name:_____
Subscriber's Date Of Birth _____ Employer _____
Subscriber's address _____

Secondary Insurance

Member ID #_____ Group # _____ Subscriber's Name:_____
Subscriber's Date Of Birth _____ Employer _____
Subscriber's address _____

Guarantor Information

Relationship to patient [ ] Self (if self, skip to emergency contact) [ ] Spouse [ ] Parent [ ] Other
First Name _____ Middle Initial _____ Last Name _____
Date of Birth_____ SSN# _____ Gender [ ] M [ ] F
Mailing Address _____ Apt# _____ City _____
State _____ Zip Code _____
Home Phone _____ Work Phone _____ Cell Phone _____
Employer & Phone _____

Employment Status [ ] Active Duty [ ] Employed **FT** [ ] Other [ ] Employed **PT** [ ] Retired [ ] Self Employed

Emergency Contact Information

Last Name _____ First Name _____
Relationship to Patient _____
Mailing Address _____ Apt# _____ City _____
State _____ Zip Code _____
Home Phone _____ Work Phone _____ Cell Phone _____