WELCOME TO UAB EYE CARE

Patient Information Form

Patient Information Todays Date:_____

Patient Name: Last:_____ First:_____ Middle Initial: ____
Sex: Male ☐ Female ☐ Date of Birth (month/day/year) _____
☐ Mr. ☐Ms. ☐Mrs.

Address Information

Street: _____ City:_____ State:____ Zip _____
Country _____ Type _____
Home Ph# (____)_____ Wk#(____)_____ Cell#(____)_____
E-mail address: _____

Information

Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Social security number: _____
Mothers maiden name/birth state: _____
(Please be aware that the social security number and mothers maiden name are used as security questions to protect your account and patient information)
Your primary language is: _____
Do you have any special needs? (wheel chair, deaf, blind, etc)_____
Race: ☐ Caucasian ☐ African/American ☐ Hispanic/Latino ☐ Asian ☐ Pacific Islander ☐ Native American
☐ Other _____

Your occupation: _____ Employer: _____
Are you a UAB student or UAB employee? _____

Insurance Information

Name of insured _____ Date of birth: _____
Relationship to patient: _____ Social Security # _____
Name of employer: _____
Address of employer_____City:_____State:_____Zip:_____

Insurance company name_____
Group#_____ ID#/Policy#_____
Insurance company phone number:_____

Do you have any other insurance information? _____ if so complete below

Name of insured _____ Date of birth: _____
Relationship to patient: _____ Social Security # _____
Name of employer: _____
Address of employer_____City:_____State:_____Zip:_____

Insurance company name_____
Group#_____ ID#/Policy#_____
Insurance company phone number:_____

Signature_____ Date: _____