Weigel Family Eye Care, Optometrists, PC

Drs. David J. Weigel, O.D., Eric D. Weigel, O.D.
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Date: _____ Daytime/Home Phone: (_____)_____
Patient:_____ Cell Phone: (_____)_____
OK to receive Text Messages: YES or NO

Street Address: _____
City:_____ State:_____ Zip:_____
Sex: __M____F____ Date of Birth:_____ Social Security #_____

Single	Married	Widowed	Divorced	Separated

Patient Employed by:_____
_____
Occupation: _____

Primary Insured Name:_____ Date of Birth: _____/_____/_____
_____ Social Security #: _____
Insured's Work:_____ Phone: (_____) _____
_____
Occupation: _____

In case of emergency, notify: _____ Phone: (_____)_____

Preferred Language:

English	Spanish	French	Japanese

Race:

American Indian Or Alaska Indian	Asian	Black or African American	Hispanic	Native Hawaiian or Other Pacific Island	White

Ethnicity:

Hispanic or Latino	Native Hawaiian or other Pacific Island	Not Hispanic or Latino

Communication Preference:

Email	Telephone	Postal

Email Address: _____

HIPAA … I have received a copy of the privacy notice.

Patient (print name) _____

Patient (signature) _____ Date: _____

You must be 18 or older to sign. If under the age of 17 legal guardian or parent must sign.