PRAIRIE
Eye Center, LTD

Patient Information

Legal name required for insurance purposes (Please print)

Name: (first / middle / last) _____

Date of Birth: _____ SS#: _____ Gender: (circle one) M / F / Nonbinary

Marital Status: (circle one) Single Married Domestic Partner Separated Divorced Widowed

Race: (circle one) American Indian / Alaskan Native / Asian / African American / Pacific Islander / White / Latin American / Decline

Ethnicity: (circle one) Latino / Not Latino / African American / American / Native American / Chinese / European American / Decline

Preferred Language: (circle or add) English / _____

Address: _____ City/State: _____

Zip: _____ County: _____

Cell #: ( ) _____ Email: _____

Home #: ( ) _____ Work #: ( ) _____

Employer: _____ Occupation: _____

PCP/Family Doctor: _____ Office #: _____

Responsible Party / Guarantor

Name: (first / middle / last) _____Date of Birth: _____

Address: _____ City/State: _____ Zip: _____

Phone #: ( ) _____ Email: _____

Relation to patient: _____ Preferred contact method: _____

Emergency Contact (for minor child may be used for other parent)

Name: (first / middle / last) _____ Relation to patient: _____

Cell #: ( ) _____ Phone # : ( )_____

Insurance Information (please provide current insurance cards)

- Primary Ins. Co.: _____ ID/SSN: _____
- Policy Holder Name: _____ Birthdate: _____
- Secondary Ins. Co.: _____ ID/SS#: _____
- Policy Holder name: _____ Birthdate: _____

Patient / Legal guardian signature: _____ **Date:** _____