ABILENE PREMIER EYE CARE, ANCA D. PACURARU, D.O.

PATIENT INFORMATION

(Please print clearly)

DATE _____

Name _____ Phone # (Home) _____
LAST FIRST MIDDLE

Mailing Address _____ Phone # (Work) _____

City _____ State_____ Zip _____ Phone # (Cell)_____

Email _____

Contact Preference: ☐ Home phone ☐ Work phone ☐ Cell phone ☐ Email

Sex: ☐ M ☐ F Birthdate ____ /____ /____ ☐ Single ☐ Married ☐ Other_____

SS#_____ Occupation_____

Employer_____ Name of Spouse or Guardian _____

Person responsible for account _____ Emergency Contact Name _____

Phone # _____ Relationship to Emergency Contact _____

Release Medical Information ☐ Yes ☐ No

Name of your Pharmacy _____ Phone # _____

Primary Care Physician_____ Last visit (date) ____ /____ /____

Phone # _____

Do you have another Eye Doctor? ☐ Yes ☐ No Did they ask you to come see us? ☐ Yes ☐ No

Eye Doctor's Name/Address/Phone _____

Date of last exam ____ /____ /____ Do you wear: ☐ Glasses ☐ Contact lenses

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Declined to specify

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Declined to specify

Language: _ English _ Spanish _ Vietnamese _ Mandarin _German _ French _ Hindi _ Korean
_Tagalog _ Sign Language or other Auxiliary Aid/Service _ Decline to specify _ Other

HEALTH INSURANCE COVERAGE

PLEASE INCLUDE ANY LETTERS WITH ID#. COPY OF INSURANCE CARD WILL BE REQUIRED

Primary Carrier _____ ID# _____ Grp# _____

Subscriber: ☐ Self ☐ Spouse ☐ Parent ☐ Subscriber Date of Birth ____ /____ /_____

Secondary Carrier _____ ID# _____ Grp# _____

Subscriber: ☐ Self ☐ Spouse ☐ Parent ☐ Subscriber Date of Birth ____ /____ /_____

IF THE NAME OF THE INSURANCE POLICYHOLDER IS OTHER THAN THE PATIENT, PLEASE COMPLETE

Name of Policyholder _____

Address of policyholder _____ City _____ State ____Zip_____

Phone# (Policyholder) _____

Date of Birth ____/____/_____Employer of Policyholder _____