MR#:_____
Office Use Only

PLEASE COMPLETE IN BLACK OR BLUE INK **DATE:** _____

PATIENT INFORMATION

LAST **NAME:** _____ ***FIRST*** **NAME:** _____ **MIDDLE INITIAL:** _____

SOCIAL SECURITY #: _____ **BIRTHDATE:** _____ **SEX: M F**

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

HOME PHONE #: _____

DAYTIME PHONE #: _____ **Is this a work #? Yes No *If yes, please list Employer below.**

CELL PHONE #: _____

DRIVER'S LICENSE #: _____**STATE:** _____

MARITAL STATUS: ☐ **MARRIED** ☐ **SINGLE** ☐ **WIDOWED** ☐ **SEPARATED** ☐ **DIVORCED**

SPOUSE'S NAME: _____ **PHONE #:** _____

RACE: ☐ **African-American** ☐ **Asian** ☐ **Caucasian** ☐ **Hispanic** ☐ **Other** _____

LANGUAGE SPOKEN: _____ **VETERAN:** ☐ Yes ☐ No

FAMILY DOCTOR (PCP): FIRST_____LAST_____**CITY:** _____

PHARMACY: _____**STREET:** _____**CITY:** _____

***EMPLOYER:** _____ **ADDRESS:** _____

WHO REFERRED YOU TO OUR OFFICE: _____

In Case of Emergency, please list a Family Member or Friend NOT LIVING WITH YOU:

NAME: _____ **RELATIONSHIP:** _____ **PHONE:** _____

STREET ADDRESS: _____ **CITY:** _____ **STATE & ZIP:** _____

- Please select your ***preferred*** contact number for **appointment call reminders.**
  - ☐ **HOME #:** _____
  - ☐ **CELL#:** _____ **This may include text messages.**
  - ☐ **WORK#:** _____
- Our office utilizes a "Patient Portal", an online website patients can access their health information, appointments, medication requests and communicate via a secure email system with our practice. Please list your email address:

Email _____

INSURANCE INFORMATION - Please bring your insurance card(s) & photo ID to Appointment

X_____
SIGNATURE OF PATIENT (Guardian or Parent Signature, if minor)

Jeffries Eye Associates
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Rogers, AR 72758
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