ESTACADA
EYECARE PC

Patient Information

Patient Information

Name: _____ Gender: ◯ Male ◯ Female ◯ Other

Preferred Name: _____

Date Of Birth: _____ Marital Status ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Ethnicity/Race: ◯ Native Hawaiian or Other Pacific Islander ◯ American Indian or Alaska Native ◯ Asian
◯ Caucasian ◯ Black or African American ◯ Hispanic or Latino ◯ Not Hispanic or Latino

Phone Number _____ Email _____

Address _____

_____

Emergency Contact Information

Name _____ Relationship _____

Phone Number _____ Email _____

Primary Care Physician

Name _____

Phone Number _____ Email _____

Referral Information

Were you referred to our practice? ◯ Yes ◯ No | If yes, by whom? _____

Consent and Acknowledgement

I, the undersigned patient (or legal guardian) of above named patient, hereby authorize and give my consent for any diagnostic or medical treatment or procedure deemed necessary by the physician or healthcare provider.

I have been informed of the potential risks and benefits of the recommended treatment, and I have had the opportunity to d I have had the opportunity to ask any questions I may have.

_____ _____

Patient's Signature ***Date***

_____ _____

Patient's Legal Representative (if applicable) ***Date***