Clay Eye
Physicians & Surgeons

OPHTHALMOLOGY - DISEASES AND SURGERY OF THE EYE

Macular Degeneration & Diabetes Eye Institute of Northeast Florida

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DATE:_____ MARITAL STATUS: ❑M ❑W ❑S ❑D

PATIENT NAME: _____ DOB: _____

ADDRESS: _____ AGE:_____SEX:_____

CITY: _____ STATE: _____ ZIP: _____ SSN: _____

HOME PHONE: _____ALT PHONE:_____

EMPLOYER: _____WORK PHONE: _____

MAY WE CONTACT YOU VIA EMAIL? ❑YES ❑NO E-MAIL ADDRESS:_____

ARE YOU A VETERAN? ❑YES ❑NO DRIVER'S LICENSE #: _____

SPOUSE NAME:_____ SPOUSE DOB:_____

SPOUSE'S EMPLOYER: _____WORK PHONE: _____

EMERGENCY CONTACT: _____ PHONE: _____

PRIMARY INSURANCE NAME: _____ ID# _____

PRIMARY CARD HOLDER NAME: _____ DOB:_____RELATION:_____

SECONDARY INSURANCE NAME: _____ ID# _____

SECONDARY CARD HOLDER NAME: _____ DOB:_____RELATION:_____

IS THIS ACCIDENT OR INJURY RELATED TO: ❑AUTO ❑JOB ❑OTHER DATE OF INJURY: _____

PRIMARY CARE PHYSICAN: _____ PHONE: _____

PHARMACY: _____ PHONE: _____

TO BE IN COMPLIANCE WITH FEDERAL GUIDELINES, PLEASE INDICATE WHICH OF THE FOLLOWING BEST DESCRIBES YOU:

RACE: ❑ American Indian or Alaska Native ❑ Asian ❑ Black of African American
❑ More than one race ❑ Native Hawaiian or Pacific Islander ❑ White
❑ Other ❑ Unknown/Not Reported

ETHNICITY: ❑Hispanic or Latino ❑ Not Hispanic or Latino ❑ Unknown/Not Reported

PRIMARY LANGUAGE: _____

HOW DID YOU HEAR ABOUT CLAY EYE PHYSICIANS & SURGEONS? (check all that apply)

❑ Referring Physician:_____❑Friend/Family:_____

❑Hospital Consult ❑Website ❑Health Fair ❑Insurance Referral

❑Emergency Room Consult ❑Print Ad ❑ Other:_____