THE REGIONAL EYE CENTER®
Always looking ahead.

PATIENT INFORMATION SHEET

Date______________

Last Name____________________**First Name**______________________ **Middle**____________________

Social Security Number____ -______-_______ **Date of Birth**____________ **Age**______ **Sex** ____Male ____Female

Mailing Address ______________________________ City______________________ State_____ Zip________

Home Address (if different)______________________ City______________________ State____ Zip_________

Phone: Home (____) _____________ Work (____) ______________ Ext_____ Cell (____) _____________

What is your preferred phone number for our use in contacting you? ____Home ____Work ____Cell

E-mail Address____

Were you Referred by Physician ____Yes ____No if yes, Name:___________________________________

Referred by _______Friend ________Relative

Language: *1____English 2____Spanish 3____Chinese 4____German 5____OTHER*

Primary Care Physician: ______________Address (city/state)____________________________________

Marital Status 1 ____Single 2 ____Married 3 ____Widow(er) 4____Divorced

As required by the Department of Health, the State of Tennessee mandates us to ask you the following questions*:*

Race: *1___White/Caucasian 2____Black/African American 3___ Native American Indian/Alaskan Native*

.... 4___ Asian/Pacific Islander 5_Other Race (other than 1-4) 9_____Unknown Race

Language Barrier*: ____NONE ____YES-Other Than English ____YES-Sign Language*

Ethnicity*: 1___ Hispanic Origin 2___Non-Hispanic Origin 3____Hispanic Origin Unknown*

Have you been seen by The Regional Eye Center Previously? ____Yes _______ Year ___________by Whom

_____ No

Employer___________________________________Address__________________________________

Spouse's Name__________________________Work Phone (____) ___________Date of Birth___________

Spouse's Employer ________________________________Address______________________________