PATIENT INFORMATION

PATIENT NAME: ____ **DATE OF BIRTH:** ______/______/______
FIRST MIDDLE LAST **MONTH DAY YEAR**

ADDRESS: ____
NUMBER & STREET APT NO. CITY STATE ZIP CODE

HOME PHONE: ________________________ **MOBILE PHONE:** ____________________________

RACE: AMERICAN INDIAN or ALASKAN NATIVE ASIAN PACIFIC ISLANDER BLACK or AFRICAN AMERICAN CAUCASIAN
(*not required*) OTHER

ETHNICITY: HISPANIC NON-HISPANIC **LANGUAGE SPOKEN:** ______________________________
(*not required*)

PRIMARY CARE PHYSICIAN: ______________________ **REFERRED BY:** ______________________

HAS ANY FAMILY MEMBER BEEN SEEN HERE BEFORE? YES NO

IF YES, PLEASE SPECIFY NAMES: ____

PERSON RESPONSIBLE FOR PAYMENT: ____

RELATIONSHIP TO PATIENT: ______________________ **SOCIAL SECURITY NUMBER** ________________

ADDRESS (IF DIFFERENT FROM PATIENT): ____
NUMBER & STREET CITY STATE ZIP CODE

NAME & ADDRESS OF EMPLOYER: ____

If you wish to share your personal health information with another individual, you must complete the following:

If you would like to authorize Newton Wellesley Eye Associates to share your medical information with the following contact person:

______________________	______________________	______________________
NAME OF CONTACT	**CONTACT'S DATE OF BIRTH**	**RELATIONSHIP TO PATIENT**

ACKNOWLEDGEMENT TO NOTIFICATION OF PRIVACY PRACTICES, AND CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: I understand that Newton-Wellesley Eye Associates, P.C. has a Notice of Privacy Practices that describes how my health care information is used and shared with others. I understand that I have a right to request a copy of the Notice and that I have a right to read the Notice before signing this consent.
By signing below, I acknowledge the notification of Newton-Wellesley Eye Associates' Notice of Privacy Practices, and consent to the uses and disclosures therein.

______________________________________ ______________________
PRINT NAME (PATIENT/PARENT/LEGAL GUARDIAN) **RELATIONSHIP TO PATIENT**

______________________________________ ______________________
SIGNATURE OF: PATIENT / PARENT / LEGAL REPRESENTATIVE OR GUARDIAN **DATE**