Eye Care Pavilion

Eye Care Pavilion, P.L.C.
4310 East 53rd Street
Davenport, Iowa 52807

Today's Date _____/_____/_____

Patient's Name: _____ Date of Birth: _____/_____/_____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Are you currently a student? ☐ Full Time ☐ Part Time ☐ Not a Student

Are you currently working? ☐ Yes ☐ No Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Disabled

Occupation: _____ Employer: _____

SSN: _____-_____-_____

Name of person responsible for this account: _____

Address: _____ City: _____ State: _____ Zip: _____

SSN: _____-_____-_____

Communication Preference: ☐ Phone Call ☐ Mail ☐ Email: _____ ☐ Text

Preferred Language: ☐ English ☐ Spanish ☐ Other _____ ☐ I choose not to specify

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Native Hawaiian or other Pacific Islander ☐ I choose not to specify

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ White/Caucasian

☐ Native Hawaiian or other Pacific Islander ☐ I choose not to specify

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Emergency Contact _____ Phone Number _____

Relationship _____

Whom may we thank for referring you to this office? _____

I have been given a copy of Eye Care Pavilion's Privacy Practice:

Signature: _____

Names of family/friends that you give permission to share your medical/personal information with:

Name: _____ Phone _____

Name: _____ Phone _____

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be paid directly to the physician and I am financially responsible for non-covered services. I authorize the physician to release any information required to process this claim. I also authorize you to give me reasonable and proper medical care by current standards.

I have reviewed my personal information and it is correct.

Patient/Legal Guardian Signature: _____

Date: _____