Welcome to

Hawks Prairie Vision Clinic

Thank you for selecting us to care for your vision health. If you have any questions or need assistance, we will be happy to help!

Patient Demographic Form

(This form may need to be updated at every visit with any information changes)

Section 1: Patient Information

Today's Date_____ **Patient's Date of Birth**_____

Patient's Name_____

(First) **(M.I.)** **(Last)**

Preferred Name_____ **Social Security Number** _____-_____-_____

Gender: **Male** ☐ **Female** ☐

Address_____ **City**_____ **State**_____ **Zip**_____

Home Phone(_____)_____ **Cell Phone**(_____)_____ **Texting OK?**

Email Address_____@_____ **YES** ☐ **NO** ☐

Race:

- ☐ **Native American Indian**
- ☐ **Asian**
- ☐ **African American**
- ☐ **Hispanic**
- ☐ **Hawaiian**
- ☐ **Filipino**
- ☐ **Caucasian**
- ☐ **Decline to Specify**

Ethnicity:

- ☐ **Hispanic or Latino**
- ☐ **Not Hispanic/Latino**
- ☐ **Unknown**
- ☐ **Decline to Specify**

Section 2: Person Financially Responsible For This Account	
Relationship to Patient (**circle one**): Self Parent Other	Social Security Number:
Name:	Date of Birth:
Employment (**circle one**): F/T P/T Retired Unemployed	Home Phone: ( )
Employer Name:	Cell Phone: ( )
Employer Address:	Work Phone: ( )

Section 3: Insurance Information

Please present your insurance card to the receptionist to make a copy

	Primary Vision	**Primary Medical**	**Secondary Vision**	**Secondary Medical**
Insurance Name:				
Member ID:				
Group ID:				
Policyholder Name:				
Policyholder Date of Birth:				
Relationship to Patient:				