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

Patient's Name____**Date of Birth**__________________
(First) (Last)

Preferred Name____________________________**Social Security Number**______-______-_______
Address______________________**City**____________________**State**_______**Zip**_________
Home Phone(______)___________**Cell Phone**__(______)_____________**Texting OK?** YES☐ NO☐
Email Address________________________@______________Gender: Male☐ Female ☐
Preferred Language (please write if other than English):____________________________________

Race:
- ☐ American Indian
- ☐ Asian
- ☐ African American
- ☐ Hispanic
- ☐ Native
- ☐ Hawaiian
- ☐ Phillipino
- ☐ Caucasian
- ☐ Decline to Specify

Ethnicity:
- ☐ Not Hispanic/Latino
- ☐ Hispanic or Latino
- ☐ Unknown
- ☐ Decline to Specify

Section 2: Person Financially Responsible For This Account

Name:	Date of Birth:
Relationship to Patient (**circle one**): **Self Spouse Parent** **Other:**	Social Security Number:
Street Address:	Home Phone: ( ) -
City/State/Zip:	Work Phone: ( ) -
	Cell Phone: ( ) -
Employer: (**please enter**)	

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				

Signature of Responsible Party_______________________________________**Date**____________