MILWAUKEE EYE CARE

Patient Information

PLEASE PRINT CLEARLY

☐ Female ☐ Male ☐ Non-Binary ☐ Non-Designated ☐ Decline to Answer

20 ____ Year

☐ Additional Category (Please Specify) _____

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Mx. ☐ Dr. ☐ Other _____

Last Name	First Name	Middle Initial	Date of Birth (/ /)

Mailing Address _____ Apt. # _____

City _____ State _____ Zip Code _____

Patient Social Security Number: _____ - _____ - _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Employer: _____ Occupation or Former: _____

Primary Care Physician: _____ Phone: _____

How did you hear about our office? _____

Emergency Contact: _____ Phone: _____

INSURANCE POLICY HOLDER (Person responsible for the bill – if different from patient)

Last Name	First Name	Middle Initial	Date of Birth (/ /)

Mailing Address _____ Apt. # _____

City _____ State _____ Zip Code _____

Guarantor Social Security Number: _____ - _____ - _____

Relationship to Patient: _____