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Diplomates, American Board of Ophthalmology
Corneal, Cataract, Refractive Surgery & Uveitis

Website: www.CorneaAZ.com

Patient Information

Date _____

Race:
☐ White or Hispanic
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Pacific Islander
☐ American Indian or Alaskan Native

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Tobacco Use:
☐ Current
☐ Not Current
☐ Unknown

Preferred Language _____

Mrs. ☐ Ms. ☐
Mr. ☐ Dr. ☐ Name _____ Age _____ Birthdate _____-_____-_____

Arizona address _____
St., Rt., Box # City State Zip

Phone # _____ ☐ Yes, I want online access Email _____

Cell # _____

Social Sec. # _____-_____-_____ Marital Status _____

Employer _____ Phone # _____

Complete Business Address _____ Title _____

Insurance Co. _____ Name of Insured _____

Name (Spouse/Parent) _____ Birthdate _____-_____-_____

Insurance Co. _____ Soc. Sec # _____-_____-_____

Employer _____ Phone # _____

Complete Business Address _____ Title _____

Persons authorized to access my medical information ☐ **Relative** ☐ **Other**

Name _____ Phone # _____ Relationship _____

Name _____ Phone # _____ Relationship _____

Person Responsible For Payment (Other than patient):

Name _____ Phone # _____

Address _____
St., Rt., Box # City State Zip

Who referred you to this office? _____

Who is your medical doctor? _____ Telephone _____

Patient Signature _____