BRAVERMAN-TERRY-OEI EYE ASSOCIATES
EXCELLENCE IN EYE CARE

Patient Information Form

(Please Print)

Patient's Name/*Nombre*: _____

Date of Birth/*Fecha De Nacimiento*: _____ Age/*Edad*: _____ Sex/*Sexo*: _____

Check One: ○ Child/*Nino(a)* ○ Single/*Soltero(a)* ○ Married/*Casado(a)*
○ Separated/*Separado* ○ Divorced/*Divorciado* ○ Widow/*Biudo(a)*

Check One: ○ White ○ African American ○ Asian/Native Hawaiian/Pacific Islander
○ Hispanic/Latino ○ American Indian/Eskimo/Aleu ○ Other

Address: _____
Number & Street/*Domicilio or Direccion* City/*Cuidad* State/*Estado* Zip Code/*Codigo Postal* Phone/*Telefono*

Social Security Number/*Seguro Social*: _____ Driver's License Number/Licensia *de Conducir*: _____

Patient's Employer/*Empleo*: _____

Occupation/*Ocupacion*: _____ Phone/*Telefono*: _____

Spouse's Name/*Nombre De Esposo(a)*: _____ Birthday/*Fecha de Nacimiento*: _____

Spouse's or Parent's Employer/*Empeo De Esposo(a)/ Padre/Madre*: _____

Family Physician/*Su Doctor Familiar*: _____ City/*Cuidad*: _____ Phone/*Telefono*: _____

In case of emergency contact:/*En caso de emergencia*: _____
Name/*Nombre* City/*Cuidad* Phone/*Telefono*

Patient was referred by/*Quien lo/la referio aqui?*:

○ Doctor Name/*Nombre*: _____

Specialty/*Especialidad*: _____ Phone/*Telefono*: _____

○ Other/*Otro*: _____

I request Braverman-Terry-Oei Eye Associates and Staff to perform those tasks necessary for medical care. I understand that I may be given a return appointment in order to follow-up on my ocular status or condition. In the event that, for any or no reason, I do not keep that return appointment and do not promptly re-schedule, I agree not to hold Braverman-Terry-Oei Eye Associates , it's Physicians, and/or staff responsible for any resulting consequences. All charges will be submitted to my insurance and I am responsible for that part not covered.

Les doy permiso a Braverman-Terry Eye Associates para que me den atencion medica. Ud (el paciente) va ser responsible para los cargos que su seguranza no cubre. Entiendo que puedo ser dado una cita del regreso para seguimiento en mi posición o la condición oculares. En caso de que, por cualquier o ninguna razón, yo no mantenga esa cita del regreso y no reprograme inmediatamente, concuerdo en no tener Socios de Ojo de Braverman-Terry y Oei, es Médicos, y sus empleados responsable de ninguna consecuencia resultante. Todos cargos se someterán a mi seguro y yo soy responsable de esa parte no cubierta.

The patient was informed at the time their appointment was schedule that the examination would take approximately two hours, that their eyes would be dilated, and that they would need to arrange for a driver to return home.

El paciente fue informado que la cita puede durar aproximadamente 2 horas, y sus ojos van a ser dilatodas y va necesitar un chofer.

Patient's Signature/*Firma del paciente*: _____ Date/*Fecha*: _____

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