

#### COEUR D'ALENE OFFICE

2175 N. Main St. (Riverstone), Coeur d'Alene, ID 83814 Phone (208) 664-9888 | Fax (208) 666-0816

### SPOKANE VALLEY OFFICE

16010 E. Indiana Ave., Spokane Valley, WA 99216 Phone (509) 928-8040 | Fax (509) 928-0784

# **Patient Demographics Information Form**

Patient Information					
Legal Name			Date		
Last	First	MI			
Preferred			$\square$ Male	$\square$ Female	
Birth Date//	Age	Social S	Security		
Employer/School		Occupation	on		
How did you choose this office?	$\square$ Referred by P	atient $\square$ Referred	d by Doctor	$\square$ Location $\square$ Other	
Medical Doctor	Ref	erring Physician	(if applicable	e)	
Last Medical Exam/	_/	Last Eye Exam//			
Marital Status ☐ Married (Spous	e Name)		Single	☐ Widowed ☐ Divorced	
Contact Information					
Billing Address		Primary Phone			
City/ State/ ZIP		Alt. Phone			
Email					
<b>Emergency Contacts</b>					
Name		elationship		Phone	
Name	R	elationship		Phone	
Patients Under 18 Years					
Parent/ Guardian Name			P	Phone	
Relationship					
Street Address(If different than above)		City /Sta	ite/ Zip		
<u>Insurance</u>					
Primary Insurance	ary Insurance Secondary Insurance				
			Policy #		
olicy Group # Policy Group #					
Policy Holder Name Pol			icy Holder Name		



**EmpireEye.com** 

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Rela	ationship	Relationship		
For	Office Use Only MRN	Picture on File? ☐ Yes ☐ No ☐ Refused		
A 1 2	Povisod 1/13/2020			

A12 Revised 1/13/2020