ROCKWALL EYE ASSOCIATES

2380 S. Goliad St., Suite 100
Rockwall, TX 75032
Phone: 972-771-2020 | Fax: 972-722-4858

PATIENT DEMOGRAPHICS

Today's Date _____ Referring Doctor: _____ OD / MD / DO

PATIENT INFORMATION: (Please use the full legal name, no nicknames)

Last Name: _____ First Name: _____ Middle Initial: _____

Social Security #: _____-_____-_____ Date of Birth: _____-_____-_____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone #: (_____) _____-_____ Secondary Phone #: (_____) _____-_____

Is it ok to leave a message on your voice mail Yes / No

Do you wish to have access to the Patient Portal? Yes / No If yes, please fill in email address below.
Email Address: _____

Primary Medical Insurance Card Holder Name_____ Date of Birth_____

SEX: ☐ Female ☐ Male

MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

RACE: ☐ American Indian ☐ Asian ☐ African American / Black ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other ☐ Declined to Specify

LANGUAGE: ☐ English ☐ Spanish ☐ Other ☐ Declined to Specify

ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic ☐ Unknown ☐ Declined to Specify

Please present a photo ID and your Insurance card(s) to the receptionist at your appointment.

Emergency Contact: _____ Relationship: _____ Phone #: (_____) _____-_____

_____ _____

Patients Signature Date