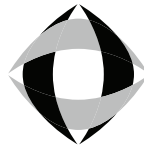


Account # (Office Use Only): _____

Date: _____



DRS. CAMPBELL CUNNINGHAM
TAYLOR & HAUN

PATIENT INFORMATION SHEET (PLEASE PRINT)

Last Name: _____ First Name: _____ MI: _____

Physical Address: _____

City: _____ State _____ Zip _____

Phone: Preferred (Home) _____ (Cell) _____

Email: _____

We are encouraging our patients to use our portal, Follow My Health (Eye Link), to participate in their healthcare and communicate with our practice. YES (Email Required) NO

Date of Birth: _____ Social Security #: _____

Gender: Male Female Marital Status (Circle One): Married Single Divorced Widowed

Ethnicity: Asian Black Caucasian/White Hispanic Other?

Employer: _____ Employer Phone #: _____

Spouse or Guardian Name: _____ Phone #: _____

Spouse or Guardian Date of Birth: _____ Social Security #: _____

Emergency Contact: _____ Phone #: _____ Rel: _____

Please list the person whom we can share your Protected Health Information with:

Referring Physician: _____ Phone #: _____

Primary Care Doctor: _____ Phone #: _____

Pharmacy Name: _____ Phone #: _____

Do you have a Living Will? Yes No Power of Attorney? Yes No

INSURANCE INFORMATION: Please provide insurance cards and photo ID to receptionist

Primary Insurance: _____ Secondary Insurance: _____

Subscriber's Name: _____ DOB: _____

How did you learn about our practice? (Please Circle One)

Friend Internet Word of Mouth Doctor TV Radio Current Patient
Relative Shopper Insurance Walk-In Saw Building Sign Mailer