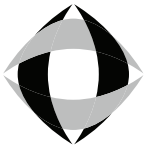
Account # (Office Use Only): _____ Date: _____



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