



**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/Viudo(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 Espos(a): \_\_\_\_\_ Birthday/Fecha de Nacimiento: \_\_\_\_\_

Spouse's or Parent's Employer/Empeo De Espos(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, its 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 responsable para los cargos que su seguridad no cubre. Entiendo que puedo ser dado una cita del regreso para seguimiento en mi posición o la condición ocular. 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 dilatadas y va necesitar un chofer.*

Patient's Signature/Firma del paciente: \_\_\_\_\_ Date/Fecha: \_\_\_\_\_