Munster Eye Care Associates, P.C.

Comprehensive Ophthalmology/Optometry and Optical Dispensary

759 45th Street, Suite 101 • Munster, IN 46321

219.922.6226 • F 219.922.8784

munstereyecare.com

Current Date: ______

Patient Information
(Patient Demographic Tab)

Last Name:	First Name:	MI:	Nickname:	Sex:	Salutation:

Suffix:	Birth Date:	Provider:

Address

Street:	City:	State:	Zip:	Country:	Type:

Communication

Preference: ☐ E-mail ☐ Phone – Cell ☐ Phone – Home ☐ Phone – Work ☐ Text ☐ U.S. Mail

Home:	Work / Extension:	Cell:	Carrier:	Email:
(219)	(219)	(219)		☐ I do not have an e-mail account

Information

SSN:	Marital Status:	Primary Language:	Special Needs:

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Decline to Answer

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Other Race ☐ White ☐ Decline to Answer

Occupation	Employer

Account Responsible (Complete only if other than patient)
(Acct Responsible Tab)

Last Name:	First Name:	MI:	Salutation:	Birth Date:	Suffix:

Patient Relationship:	SSN

Address

Street:	City:	State:	Zip:

Communication

Home:	Work # / Extension:	Email:	☐ I do not have an e-mail account.

Emergency Contact
(Contacts Tab)

Salutation:	Last Name:	First Name:	MI:	Relationship:

Home Phone:	Cell:	Work Phone/ Extension:	E-mail:
			☐ I do not have an email account

Referral Information	
Doctor / Phone	Patient / Family / Friend

☐ Newspaper	☐ Internet Website	☐ Walk In/Drive By/Signage	☐ Patient	☐ Family
☐ Emergency Room	☐ Insurance Company	☐ Worker’s Compensation	☐ Other	

Medical/Vision Insurance Information

Primary Insurance Information

Insurance Company Name	Carrier Street	Carrier City		Carrier State	Carrier Zip	
Insured Person Last Name	First Name	MI	Suffix	Salutation	Insured Date of Birth	
Street Address	City	State	Zip	Home Phone ( ) -		Sex
Insurance ID #	Group Number	Group Name		Employer/School		Relationship

Secondary Insurance Information

Insurance Company Name	Carrier Street	Carrier City		Carrier State	Carrier Zip	
Insured Person Last Name	First Name	MI	Suffix	Salutation	Insured Date of Birth	
Street Address	City	State	Zip	Home Phone ( ) -		Sex
Insurance ID #	Group Number	Group Name		Employer/School		Relationship

Tertiary Insurance Information

Insurance Company Name	Carrier Street	Carrier City		Carrier State	Carrier Zip	
Insured Person Last Name	First Name	MI	Suffix	Salutation	Insured Date of Birth	
Street Address	City	State	Zip	Home Phone ( ) -		Sex
Insurance ID #	Group Number	Group Name		Employer/School		Relationship

Vision Insurance Information

Insurance Company Name	Carrier Street	Carrier City		Carrier State	Carrier Zip	
Insured Person Last Name	First Name	MI	Suffix	Salutation	Insured Date of Birth	
Street Address	City	State	Zip	Home Phone ( ) -		Sex
Insurance ID #	Group Number	Group Name		Employer/School		Relationship

Worker's Compensation Information

Date of Injury	Employer Name		Employer Representative Authorizing Treatment		
Representative Phone # ( ) -		Employer Street	Employer City	Employer State	Employer Zip
Insurance Carrier		Insurance Street	Insurance City	Insurance State	Insurance Zip
Employer Insurance Phone			Policy		