Four Corners Eye Clinic
SPECIALIZING IN MEDICAL AND SURGICAL EYE CARE

Patient Information

Your Information

Last Name:_____ First:_____ Mi:_____

Social Security No:_____

Mailing Address:_____
Street or PO Box *Apt.* *City* *State* *Zip*

Home Address:_____
(If different than mailing) *Street or PO Box* *Apt.* *City* *State* *Zip*

Sex: M / F Date of Birth:_____ Preferred Name:_____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Work Phone: (_____)_____ Fax Number: (_____)_____

Primary Phone #: ☐ Home ☐ Cell

Email Address: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ White
☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American

Ethnicity: ☐ Hispanic ☐ Not Hispanic

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Preferred Contact Method for Clinical Reminders About Your Care:

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Fax ☐ Email (via Patient Portal) ☐ Mail ☐ Do Not Contact
(We will call your primary phone number to remind you of upcoming appointments. Examples of clinical reminders may include taking your medications, following up on recommendations given by your physician, etc.)

Preferred Pharmacy

☐ Albertsons (Durango)
☐ City Market (Durango, North)
☐ City Market (Durango, South)
☐ Walgreens (Durango, North)
☐ Walgreens (Durango, South)
☐ Walmart (Durango)
☐ Rivergate (Durango)
☐ Bayfield Pharmacy (Bayfield)
☐ City Market (Cortez)
☐ Walmart (Cortez)
☐ Safeway (Cortez)
☐ Walgreens (Cortez)
☐ Safeway (Aztec)
☐ Kare (Aztec)
☐ City Market (Pagosa)
☐ Walmart (Pagosa)
☐ Walgreens (Farmington, 20th)
☐ Walgreens (Farmington, Main)
☐ Albertsons (Farmington)
☐ Target (Farmington)
☐ Walmart (Farmington,1400 Main)
☐ Walmart (Farmington, 4600 Main)
☐ Indian Health Services (Shiprock)
☐ Southern Ute Health (Ignacio)
☐ Indian Health Services (Towaoc)

☐ Other Pharmacy, including home delivery: _____

THIS IS A TWO-SIDED / TWO PAGE FORM, PLEASE COMPLETE AND SIGN PAGE 2

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Emergency Contact

Emergency Contact:_____ Contact's Phone: (_____)_____

Emergency Contact's Relationship to Patient: _____

Your Employment Information

Employer:_____ Occupation:_____

Employer Address:_____
Street or PO Box *Apt.* *City* *State* *Zip*

Insurance Information

Please list both your primary and secondary insurance, if applicable. Please provide copies of all insurance cards. We will verify that your insurance coverage is current. In the event we are unable to verify your coverage, you will be responsible for your charges until we are able to verify your coverage.

Primary Insurance Plan Name: _____

Secondary Insurance Plan Name: _____

Subscriber Name (If Different From Patient): _____

Social Security No:_____ Date of Birth:_____

Patient's Relationship to Primary Insured (Circle One): Self Spouse Child Other

Responsible Party

If the patient is a minor or there is another person who is financially responsible for the charges other than the patient, please complete the section below. When the patient is not a minor and the information below is blank and/or the patient is the only signor, the patient will be the responsible party.

Responsible Party (If Different From Patient):_____

Social Security No:_____ Date of Birth:_____

Home Phone:_____ Work Phone:_____

Home Address:_____
Street or PO Box Apt. City State Zip

Mailing Address:_____
(If Different) Street or PO Box Apt. City State Zip

Your Signature below indicates that this information is correct and accurate.

Patient Signature:_____ Date:_____

Responsible Party Signature:_____ Date:_____
(If different than patient. If Responsible Party Signature is blank, the patient is the responsible party.)