JEA
JACKSON EYE ASSOCIATES

Patient Profile

Printed on: 1/27/2017

Account	**AGE**	**DOB**	
Last Name	**First Name**	**M.I.**	
Address		**Male/Female** **Single / Separated / Divorced / Married / Widowed**	
City State ZIP		**Cell Phone**	
Email		**Home Phone**	
Contact Preference Mail / Phone / Email / Text MSG		**Alternate Phone**	
Race: _____ (or circle one) Declined / Unknown / Asian / White American Indian or Alaskan Native Black or African American		**Ethnicity: _____ (or circle one)** Other / Unknown / Declined Hispanic-Latino Not Hispanic-Latino	
Preferred Language ENGLISH SPANISH ASL other:			
Employer		**Employer Address**	
Occupation			
Employer Phone		**City State ZIP**	
Spouse: Name DOB			
Spouse Employer		**Spouse Employer Address**	
Spouse Occupation			
Spouse Employer Phone		**City State ZIP**	
I have an "Advanced Directive" YES / NO **Please Select** Living Will / Organ-Tissue Donor / Durable POA / DNR /_____			
How did you find us? _____ **or circle** Yellow Pages / Radio / Newspaper / Internet / Friend / Dr._____			
Emergency Contact: Name	**Relationship**	**Phone**	
Preferred Pharmacy		**Address**	
Pharmacy Phone			
Primary Care Physician		**Primary Care Address**	
Primary Care Phone			
Other Physician		**Other Physician Address**	
Other Physician Phone			

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	Primary Insurance	Secondary Insurance (if applicable)
Insurance Name		
Insurance ID		
Insurance Group #		
Plan Name		
Guarantor		

	Tertiary Insurance (if applicable)	Vision Insurance (if applicable)
Insurance Name		
Insurance ID		
Insurance Group #		
Plan Name		
Guarantor		

For minor patients, please fill in the following:

Mother's Information			
Account	**AGE**	**DOB**	
Last Name	**First Name**		**M.I.**
Address		**Cell Phone**	
		Home Phone	
City State ZIP		**Email**	
Father's Information			
Account	**AGE**	**DOB**	
Last Name	**First Name**		**M.I.**
Address		**Cell Phone**	
		Home Phone	
City State ZIP		**Email**	