



Dr. Alan D. Baribeau
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PATIENT INFORMATION SHEET
Welcome to the office of Dr. Alan Baribeau

Please indicate the reason for your visit: ***CHECK ALL THAT APPLY***

- Routine Eye Exam □ Diabetic Exam □ Cataract Exam/Check □ Glaucoma Exam/Check
□ Having a Medical problem:
□ Need New Glasses □ Interested in Laser Vision Correction

Patient Name: Address: City/State: Zip: Date of Birth: SSN: Cell Phone: DO YOU ACCEPT TEXT MESSAGES? YES NO
Alternate Phone: Home Work Other: Email address: Marital Status: Spouse's Name: Emergency Contact: Phone: Relationship: Employer: Employer's phone: Name of your Primary Care Doctor: Phone:

How did you hear about us? ***PLEASE INCLUDE NAMES***

- Referred by Doctor: Phone:
□ Referred by Optometrist: Phone:
□ Patient:
□ Family Member:
□ Insurance Company:
□ Internet/Website:
□ Other:

The information below is required for Electronic Medical Records:

Pharmacy Name & Location: Phone: Preferred Language: English Spanish Other: Ethnicity: Hispanic/Latino NOT Hispanic/Latino Declined to Specify Race: American Indian or Alaska Native Asian Black or African Am. Native Hawaiian/Other Pacific Islander White Declined to Specify

INSURANCE INFORMATION

Primary Ins: Secondary Ins: ID#: Grp#: ID#: Grp#: Guarantor: Self Other: Guarantor: SELF Other: