

Kansal Eye, PLLC
Ophthalmology Associates
770 N. Coit Road, Suite 2486
Richardson, Texas 75080

New Patient Information Sheet

First (Legal) Name _____ Nickname _____

Last Name _____ Date _____

Date of Birth _____ Age _____ Sex: M F

Telephone Home _____ Work _____ Cell _____

Address _____ Apt # _____ City _____

State _____ ZIP _____ Email _____

SSN _____ Spouse's/Parent's Name _____

Emergency Contact _____ Relationship _____

Emergency Contact Phone _____ Occupation _____

How did you hear about our office? _____

Another patient, who? _____ Another doctor, who? _____

What type of insurance do you have? Medicare Commercial Medicare Replacement None

Primary Care Doctor:

Name _____ Specialty _____

Address _____ Phone _____

Specialty Doctor #1 (i.e. Endocrinologist/Rheumatologist/Optometrlist):

Name _____ Specialty _____

Address _____ Phone _____

Preferred Pharmacy:

Name _____ Phone _____

Address _____