THE MIDWEST CENTER FOR SIGHT

James Katz M.D. Rakhi Patil M.D.
Hemali Dave O.D. Hillary Schweihs O.D.
8901 W. Golf Road, Suite 300
Des Plaines, Illinois 60016
(847) 824-3127
Fax (847) 824-3347

Patient Information

Referred by: ☐ **Friend/Relative**_____ ☐ **Doctor**_____
Name **Name**

☐ **Internet** ☐ **Newspaper** ☐ **Other** _____

Last Name **First Name** **Middle Initial**

Address **Apt#** **City** **State** **Zip Code**

( ) **Home Phone** ( ) **Cell Phone**

E-Mail **Social Security #** **Date of Birth** **Age** **Male/Female**

Marital Status: ☐ **Single** ☐ **Married** ☐ **Life Partner** ☐ **Legally Separated** ☐ **Divorced** ☐ **Widowed** **Smoker:** **Yes** ☐ **No** ☐

Employer **Occupation** ( ) **Work Phone Number** **Ext #**

Is this a work related injury: Yes ☐ **No** ☐

Phone number(s) we can leave a message on: **Home** ☐ **Cell** ☐ **Work** ☐

Family Physician ( ) **Office Phone Number**

Optometrist ( ) **Office Phone Number**

Pharmacy Name ( ) **Pharmacy Phone Number**

Pharmacy Address **City** **State** **Zip Code**

Emergency Contact (nearest relative or friend):

Name ( ) **Phone Number** **Relationship**

Responsible Party: Please complete this section if the patient being seen is under 18 years of age or if guarantor is other then patient.

Name **Relationship to patient**

Address **Apt#** **City** **State** **Zip Code**

( ) **Home Phone** **Social Security #** **Birthday**

PLEASE TURN PAGE OVER AND COMPLETE OTHER SIDE.
REMEMBER TO BRING COMPLETED FORMS WITH YOU ON APPOINTMENT DAY. **Date**