

THE VISION PROJECT PATIENT APPLICATION

1. Patient Information

FIRST NAME				LAST NAME					
THE MINNESOTA EYE FOUNDATION DOES NOT SHAI				RE PERSONALLY IDENTIFIABLE INFORMATION WITH ANY THIRD PARTY.					
DATE OF BIRTH GENDER FEMALE MALE			MARITAL STATUS DIVORCED SINGLE MARRIED WIDOW		_	PHONE NUMBER			
ALTERNATIVE CONTACT (FIRST AND LAST NAME)			RELATIO	RELATIONSHIP			PHONE NUMBER		
RACE NATIVE AMERICAN OR ALASKA NATIVE NATIVE HAWAIIAI ASIAN WHITE/CAUCASIA BLACK/AFRICAN AMERICAN OTHER				AN			ETHNICITY HISPANIC OR LATINO/A NON-HISPANIC OR LATINO/A		
CITIZENSHIP / IMMIGRATION STATUS U.S. CITIZEN / PERMANENT RESIDENT UNDOCUMEN ASYLEE, REFUGEE, OR PAROLEE VISITOR TO THE				ED INDIVIDUAL			ARY LANGUAGE		DO YOU NEED AN INTERPRETER? YES NO
l				(Right) OS (Left)		CTOR'S NAME		PHONE NUMBER	
3. Insurance St	atus								
PLEASE COMPLETE THE NEXT LINE.		ASSIST	IF NO, HAVE YOU APPLIED ASSISTANCE (MEDICAID) O) OR MEDICARE?		ENIED OR INELIGIBLE, WHAT WAS/IS THE REASON?		
4. Household S	ize and N	lonthly I	ncome						
HOUSEHOLD SIZE	MONTHLY HOUSEHOLD INCOME (BEFORE TAXES)		S) WAG	ALIMONY OR SPOUSAL SUPPORT SOCIAL S PENSION OR RETIREMENT INCOME SOCIAL SE				YMENT COMPENSATION CURITY DISABILITY INCOME (SSDI) CURITY RETIREMENT INCOME ENTAL SECURITY INCOME (SSI)	
5. Consent & W By signing, you atte allow the Minnesoto	st that the i	-	•						-
PRINT NAME (FIRST AND	O LAST)			SIGNATURE				 DATE	