Patient Information

Prefix: Mr. / Mrs. / Miss / Ms. / Dr. Name:_____
Prefer to be called: _____ Gender: Female / Male / _____
Date of Birth: _____ SS#: _____
Address: _____ City:_____ State:_____ Zip:_____
Cell Phone #: _____ Other #: _____
OK to Leave a Voice Message? Yes / No OK to Leave Text Message? Yes / No

EMAIL ADDRESS: _____

*****Must provide 2 phone numbers or 1 phone number and an email*****

Responsible Party for anyone under 18

Name: _____Date of Birth: _____SS#: _____
Address: _____City:_____State:_____Zip:_____
Cell phone #: _____

Patient Demographics

Racial category: African American / Asian / Caucasian / Hispanic
Native American / Pacific Islander / Other_____
Marital Status: Single / Married / Divorced / Widowed / Other_____
Patient's ethnicity: Hispanic or Latino / Not Hispanic or Latino
Patient's primary Language: English / Spanish / Other_____
Patient's smoking status: Current Every Day / Current Some Day / Heavy Smoker / Light Smoker
Former Smoker / Never Smoked / Unknown

Emergency Contact

Name: _____ Relationship: _____
Phone #: _____Cell #: _____

Employment

Circle Status: Employed Retired Student Homemaker Unemployed
Name of Employer:_____Occupation:_____

Primary Medical Insurance

Insurance Name:_____
Subscriber Name:_____ Subscriber's DOB:_____
Subscriber's Employer: _____ Subscriber's SSN#: _____

Secondary Medical Insurance

Insurance Name:_____
Subscriber Name:_____ Subscriber's DOB:_____
Subscriber's Employer: _____ Subscriber's SSN#: _____

Vision Insurance: **Vision Service Plan / Eyemed**

Subscriber Name:_____ Subscriber's DOB:_____
Subscriber's Employer: _____ Subscriber's SSN#: _____

Patient #:_____ **Employee's Initials**: _____