Name: _____ **SSN#**: _____

Date of Birth: _____ **Gender**: Male / Female

Address: _____

City: _____ **State**: _____ **Zip**: _____

Phone#: _____ **Mobile#**: _____

OK to Leave Text Message? Yes / No **OK to Leave a Voice Message?** Yes / No

Email Address: _____

Referred By: Word of Mouth / Previous Patient / Doctor: _____

Primary Care Physician (PCP): _____

Race: _____ **Marital Status**: Single / Married / Other

Ethnicity: Hispanic / Not Hispanic **Preferred Language**:_____

Smoking Status: Current Every Day / Current Some Day / Heavy Smoker / Light Smoker
Never Smoked / Unknown

Emergency Contact

Name: _____ Relationship: _____

Primary #: _____ Secondary #: _____

Employment Status: Employed / Full-Time Student / Part-Time Student
Homemaker / Retired / Unemployed

Employer: _____ **Occupation:** _____

Primary Medical Insurance

Plan Name:_____

Policy Holder:_____ Policy Holder's DOB:_____

Policy Holder's Employer: _____ Policy Holder's SSN#: _____

Secondary Medical Insurance

Plan Name:_____

Policy Holder:_____ Policy Holder's DOB:_____

Policy Holder's Employer:_____Policy Holder's SSN#_____

Do you have Vision Service Plan (VSP) or Eyemed? *(If yes, please circle which one)*