



Today's Date: _____

Patient Name: _____

Marital Status (please circle one): Single Married Other Date of Birth: _____

Age: _____ Sex: Male Female SSN: _____

Street Address: _____

City: _____ State and Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Other Phone: _____

Email Address: _____

Referred By: _____

Family Physician: _____ Optometrist: _____

Employer: _____ Occupation: _____

Employer Street Address: _____

Employer State/Zip: _____ Employer Phone: _____

Emergency Contact Name: _____

Emergency Contact Phone (other than spouse/home phone): _____

Spouse Name: _____

SSN: _____ Date of Birth: _____

Employer Name: _____

Employer Address and Phone: _____

Insurance Information (Complete if different from patient information)

Name: _____ Relationship to Patient: _____

Employer: _____ ID #: _____

Employer Address, State, Zip and Phone: _____