WELCOME TO OUR OFFICE

The information in this confidential form is required for our office to meet government mandated regulations.

Today's Date: _____

Last_____ First _____MI _____

Address: _____ City _____ State _____ Zip _____

Patient Date of Birth: _____/_____/_____ Patient Social Security No: _____

Home Phone: _____Cell Phone: _____Texting OK: ❑ Yes ❑ No

E Mail: _____@_____ Primary Care Physician: _____

Employer: _____Phone: _____ City: _____

Spouse/Parents Name: _____

Preferred Phone contact (**Circle one**): Home Work Cell

MINORS ONLY

Who are we calling? ❑Dad ❑Mom ❑Guardian Name:_____

Parent's Date of Birth: _____/_____/_____ Parent's Social Security No:_____

Insurance Information

Primary Medical Insurance: _____Member ID: _____

Member's Name: _____Member DOB: ___/___/_____ Relationship:_____

Member's Address if different from the patient: _____

Secondary Medical Insurance: _____Member ID: _____

Member's Name: _____ Member DOB: ___/___/____ Relationship: _____

Do you have a Vision Plan attached to your primary Insurance? ❑ Yes ❑ No

We Participate with the following: (circle all that apply)

Avesis VSP EyeMed VCD

***DUE TO GOVERNMENT REGULATIONS WE ARE NOW REQUIRED TO OBTAIN THE FOLLOWING INFORMATION**

*HT _____ '_____" * WT _____lbs * Preferred Language ❑English ❑Spanish

***ETHNICITY (choose one)**

❑Hispanic or Latino
❑Native Hawaiian or Other Pacific Islander
❑Not Hispanic or Latino

***RACE (choose one)**

❑ Am. Indian or Alaska Native
❑Asian
❑ Black or African American
❑Hispanic
❑ Native Hawaiian or Other Pacific Islander
❑White

***SMOKE**

❑Never Smoked
❑Current Every day Smoker
❑Current Occasional Smoker
❑Smoker, Current Status Unknown
❑Current Smokeless Tobacco User
❑Former Smoker
❑Stopped Smoking:
- ❑ Within last year
- ❑ 1-5 yrs ago
- ❑5+ years
- ❑10+ years

***ALCOHOL USE**

❑ None
❑Social use only
❑1-2 drinks daily

***NARCOTIC USE**

❑ None
❑ Recreational
❑Chemical dependence