Personal Information

Last Name: ________________________ First Name: ____________________________ MI:_______

Address: ____

City: ________________________ State: _________________ Zip Code: ______________

Home Phone: ____________________________ Work Phone: ____________________________

Cell Phone: ______________________________ Have you been here before? _______________

Date of Birth: ________/_________/___________ Social Security #: _______-_____-___________

Employer / School: _______________________ Occupation / Grade: ______________________

Email: ____ Sex: M F

Preferred contact: □ Call □ Text □ Email Status: □ Married □ Single

Insurance

Do you have Vision Insurance? □ Yes □ No If yes, which provider? __________________________

Insurance Member ID #: ________________________ Group Number: ____________________

Name of Primary holder and DOB: ____

Do you have Medical Insurance? □ Yes □ No If yes, which provider? __________________________

Insurance Member ID #: ________________________ Group Number: ____________________

Name of Primary holder and DOB: ____

Emergency Contacts

Name:____ Number:___________________________

Name:____ Number:___________________________

How did you find our office?

- □ Yellow Pages (print)
- □ Yellow Pages (online)
- □ Internet Search (Google, etc)
- □ Location
- □ Insurance Plan
- □ Family/Friends
- □ Radio
- □ Mail Out
- □ Doctor Referral