



\_\_\_\_\_  
**Today's Date**

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
Social Security #

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Middle

\_\_\_\_\_  
If Under 18, Parent/Guardian's Name(s)

\_\_\_\_\_  
Nickname and/or Title

*Please check:*

\_\_\_\_\_  
Address

- Male
- Female

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

*Please check:*

\_\_\_\_\_  
Home Phone

- Married
- Widowed
- Single
- Divorced
- Legally Separated

\_\_\_\_\_  
Daytime Phone

*Please check:*

\_\_\_\_\_  
Mobile Phone

- Employed Full-Time
- Employed Part-Time
- Self-Employed
- Retired
- Full-Time Student
- Part-Time Student
- On Active Military Duty
- Not Employed

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
Employer/School

\_\_\_\_\_  
Occupation

\_\_\_\_\_  
Referred By

**INSURANCE INFORMATION:**

\_\_\_\_\_  
Primary Medical Insurance

\_\_\_\_\_  
Primary Insured's Name

\_\_\_\_\_  
Secondary Medical Insurance, If Any

\_\_\_\_\_  
Primary Insured's Date of Birth

\_\_\_\_\_  
Vision Insurance

\_\_\_\_\_  
Primary Insured's Social Security #

\_\_\_\_\_  
Group Name, Employer, or Self-Insured

\_\_\_\_\_  
Primary Insured's Relationship to Patient