Patient Demographics

Patient Name (Last Name, First): ____

Gender: (M /F) Date of Birth (xx/xx/xxxx): _______________________________

Home Address: ____

City, State, Zip Code: ____

Daytime Phone: _______________________ Mobile: ______________________________

Fax: _____________________ E-mail Address: _____________________@___________

Company Name: ____

Occupation: ____

In Case of Emergency Contact: ____

Emergency Contact Phone: ____

Primary Care Physician: ____

Health Insurance Carrier: ____

Policy Number: _____________________________________

Vision Plan:____

Vision Plan Policy Number: ________________________________

Name of Policy Holder: ____

For Insurance Filing Purposes:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ prefer not to disclose

Employment Status: ☐ Full-time ☐ Part-time ☐ Not Employed ☐ prefer not to disclose

Last 4 digits of policy holder (optional) ______________

Referred by: ____

Hobbies, activities, etc.

Favorite Food/Treat

Is it alright confirm your appointments via email or text messaging?