Welcome to Our Office

Please fill out this form as it pertains to the patient being seen today

Patient
for the
Last Name: _____
First Name: _____
Middle Initial: _____
Sex: _____
Date of Birth: _____
Birth State: _____

****If patient is a minor, please enter this information

Responsible Adult
Last Name: _____
First Name: _____
Middle Initial: _____
Relationship to Patient: _____
SS# _____
Address and Phone if not the same as the patient:
_____

Address
Street: _____
City: _____
State: _____
Zip: _____
Country: _____

Contacts
Home Phone: _____
Work Phone: _____
Cell Phone: _____
E-Mail Address: _____

Please check how you would like us to contact you:
_____ Cell Phone
_____ Home Phone
_____ Work Phone
_____ E-mail
_____ Text (If your option is Text, we need to have both your cell phone number and your cell phone carrier in order to text you) Cell Phone Carrier _____
_____ U.S. Mail

Vision Insurance Plan _____
Medical Insurance Plan _____
Social Security Number _____

Primary Language
_____ English
_____ Spanish
_____ French
_____ Other Please Specify _____

Race
_____ White
_____ American Indian or Alaska Native
_____ Native Hawaiian or Pacific Islander
_____ Asian
_____ Other Race

Ethnicity
_____ Not Hispanic or Latino _____ Hispanic or Latino _____ Unknown

Mother's Maiden Name _____