TODAY'S DATE:____________________ AGE:________ MARITAL STATUS: (S M W D)

DATE OF BIRTH:____________________ SOCIAL SECURITY **LAST 4 NUMBERS**:____________________

PATIENT'S NAME:______________________________ NICKNAME:____________________

GENDER (MALE / FEMALE) **PREFERRED LANGUAGE**:____________________

RACE:____________ (____DECLINE TO SPECIFY) **ETHNICITY**:____________ (____DECLINE TO SPECIFY)

ADDRESS:____
Street City State Zip

HOME PHONE:____________________ WORK PHONE: ____________________

CELL PHONE:____________________ E MAIL ADDRESS:____________________

PATIENT EMPLOYER:____________________ OCCUPATION:____________________

PARENT #1 (IF A MINOR):____________________ CELL #:____________________

HOME ADDRESS:____
(If Different From Above) Street City State Zip

PARENT #2 (IF A MINOR):____________________ CELL#: ____________________

HOME ADDRESS:____
(If Different From Above) Street City State Zip

EMERGENCY CONTACT:____________________ PHONE:____________ RELATION:____________

PRIMARY CARE PHYSICIAN / PEDIATRICIAN NAME:____________________ PHONE:____________

INSURANCE INFORMATION

PRIMARY MEDICAL INSURANCE:____________________

POLICY HOLDER:____________________ POLICY HOLDER DATE OF BIRTH:____________________

POLICY NUMBER:____________________ GROUP NUMBER:____________________

SECONDARY MEDICAL INSURANCE:____________________

POLICY HOLDER:____________________ POLICY HOLDER DATE OF BIRTH:____________________

POLICY NUMBER:____________________ GROUP NUMBER:____________________

VISION INSURANCE (VSP, EYEMED, ETC) ____________________ POLICY HOLDER:____________________

POLICY HOLDER DATE OF BIRTH:____________________ POLICY HOLDER LAST 4 SSN:____________________

HOW DID YOU HEAR ABOUT US?

_______PHYSICIAN (NAME:______________________________) _______FAMILY _______FRIEND

_______INSURANCE _______BUILDING _______WEBSITE _______SOCIAL MEDIA

_______COMMUNITY EVENT / LECTURE / SEMINAR (PLEASE SPECIFY):____________________