Patients Name: Last: MI: First: Nickname:

DOB: / / SSN: - - Sex: M F Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Mailing Address: Suite, Apt #:

City: State: Zip: E-Mail:

Home Ph #: ( ) - Daytime #: ( ) - Cell Ph #: ( ) -

Best # to be reached: ❑ Home ❑ Daytime/Work ❑ Cell : Special Instructions:

Employment Status: ❑ Full-Time ❑ Part-Time ❑ Self-Employed ❑ Student ❑ Not-Employed ❑ Retired ❑ Military

Employer: Occupation:

Preferred Language: ❑ English ❑ Spanish ❑ French ❑ German ❑ Latin ❑ Other: Please List:

Race: ❑ White ❑ Black or African American ❑ Chinese ❑ Hispanic ❑ Indo-American ❑ Other: Please List:

Ethnicity: ❑ Not Hispanic or Latino ❑ Hispanic or Latino ❑ Native Hawaiian/ Other Pacific Islander

We need to know who has Financial Responsibility and who is the Primary / Guarantor on your Insurance

Spouse/Parent/Guardian: Last: MI: First: Relationship:

DOB: / / SSN: - - Employer: Best Ph #: ( ) -

Is the Address the same as Patients: ❑ Yes ❑ No If No, Please List Mailing Address Below:

Mailing Address: Suite, Apt #:

City: State: Zip: E-Mail:

We need to know who to contact in case of a Medical Emergency

Is your Spouse/Parent/Guardian your emergency contact? ❑ Yes ❑ No If No, Please List Below:

Emergency Contact Name: Relationship: Ph #: ( ) -

We need to know about your Insurance **Please Fill out what you know and give your Ins Cards to our Staff**

Primary **Medical** Carrier: Who is the Primary Member:

Secondary **Medical** Carrier: Who is the Primary Member:

Vision Insurance Carrier: Who is the Primary Member:

Secondary **Vision** Carrier: Who is the Primary Member:

_____ _____

Signature of Patient or Guarantor Today's Date