Patient Information

Last		First	MI
Mailing Address		Date of Birth	
City		State	Zip
Social Securtiy #		Sex M F	
Marital Status	M S W D		
Home Phone		Cell Phone	
Disabled Retired Employed		Employer	
Employer Phone			
Emergency Contact		Phone Number	
Language	English	Spanish	Japanese
Ethnicity	Non Hispanic	Hispanic	Declined
Race	White	Black/African American	American Indian/Alaska Native
	Asian	Native Hawaiian/Pacific Islander	Multiracial
	Declined		
Source	How did you hear about us?		

Responsible Party (If other than the patient)

Last		First	MI
Mailing Address		Date of Birth	
City		State	Zip
Social Securtiy #		Sex M F	
Home Phone		Cell Phone	
Disabled Retired Employed		Employer	
Employer Phone			

Insured's Information

Vision Insurance-Primary Insured's Name		Relationship to patient:
Vision Insurance-Primary Insured's Social Security #		Date of Birth
Vision Insurance Name		Employer
Medical Insurance-Primary Insured's Name		
Medical Insurance-Primary Insured's Social Security #		Date of Birth
Medical Insurance Name		Employer

We invite you to participate in our patient communication service. Features include:

Request Appointments Online
Receive Text Message Appointment Reminders
Receive Text Message and Emails when your glasses and/or contacts are ready for pickup

Email address____
Text cell number______________________________________
I agree to allow the use of my cell and email in providing these services.

Signature Date