

**Patient Information**

Last			First			MI
Mailing Address				Date of Birth		
City			State			Zip
Social Security #			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	Insurance List	Advertisement (Where?)				
	Dr. Referral (Who?)			Internet (Which site?)		
	Patient Referral (Who?)					

**Responsible Party (If other than the patient)**

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

**Insured's Information**

Vision Insurance-Primary Insured's Name						
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 online system, Demandforce. Features include:**

- Request Appointments Online
- Confirm Appointments via Email
- 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 Demandforce to use this information in providing my services.

Signature \_\_\_\_\_

Date \_\_\_\_\_