Patient Demographics

Last Name: ____ First Name: ____

Nickname: ____ Communication Preferred: □ Email □ Telephone □ Post

Street Address: ____

City: ____ State: ____________________ Zip Code: _________________

Home Phone: _______________________________________ Daytime Phone (if different): _____________________________

Cell Phone: ____ **May we text you:** □Y □ N

E-Mail Address: ____

Referred By: ____

Date of Birth: ______________________________________ Social Security #: _______________________________________

Marital Status: □ S □ D □ M □ W Sex: □ M □ F

Employment Status: _________________________________ Employer: ____

Occupation: ____ Preferred Language: _____________________________________

Race:

Native American/Native Alaskan □
Asian □
Black/African American □
Hispanic □
Native Hawaiian/Other Pacific Island □
White □

Ethnicity:

Hispanic/Latino □
Native Hawaiian/Other Pacific Island □
Not Hispanic/Latino □

Last Eye Exam: _______________________________________ Doctor: ____

rev11/20