

**PATIENT INFORMATION**

Welcome to our office. Please complete this questionnaire and return it to the receptionist at your appointment time  
So we can better assess your vision and health care needs and update our information.

Today's date \_\_\_\_\_

Patient Name \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
First Middle Last

Home Address \_\_\_\_\_  
City State Zip

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ Student \_\_\_Y \_\_\_N

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Email Address: \_\_\_\_\_ Check One \_\_\_Single\_\_\_Married\_\_\_Divorced\_\_\_Widowed

Employer: \_\_\_\_\_  
Name Address City State Zip

Referred by: \_\_\_\_\_

**SPOUSE INFORMATION**

Spouse Name \_\_\_\_\_ Are they a patient here? \_\_\_Y \_\_\_N

Spouse's Employer \_\_\_\_\_  
Name Address Phone

Spouse's Cell Phone(\_\_\_\_) \_\_\_\_\_ Spouse's birhtdate \_\_\_\_\_ Spouse's SS Number \_\_\_\_\_

**PARENT INFORMATION IF PATIENT IS A MINOR**

Mother \_\_\_\_\_ Birthdate \_\_\_\_\_ SS Number \_\_\_\_\_  
Phone Number \_\_\_\_\_ Cell Number \_\_\_\_\_ Patient here? \_\_\_Y \_\_\_N  
Employer \_\_\_\_\_

Father \_\_\_\_\_ Birthdate \_\_\_\_\_ SS Number \_\_\_\_\_  
Phone Number \_\_\_\_\_ Cell Number \_\_\_\_\_ Patient here? \_\_\_Y \_\_\_N  
Employer \_\_\_\_\_

May we leave a message if no one is available? \_\_\_\_\_ Yes \_\_\_\_\_ No