- **Name**:_____
- **Mailing Address**:_____
  _____

- **Home Phone #** _____
- **Daytime #** _____
- **Cell #** _____
- **Email address**_____

- **Date of Birth**_____**SS#**_____

- **Marital Status**: Married Single Divorced Widowed
- **Employment Status:** FullTime PartTime Retired Not Employed Student

- **Employer**_____**Occupation**_____

- **Preferred Language:** English Spanish Other
- **Race:** Black/African American White/Caucasian Hispanic Asian
- **Communication Preference:** Telephone Text message E-Mail

- **Primary Insurance**_____
- **Insured Name**_____**DOB**_____
  - **Address**_____

- **Secondary Insurance**_____
- **Insured Name**_____**DOB**_____
  - **Address**_____

- **Vision Insurance**_____

_____ **Date:**_____

Signature of Patient or Guardian