PATIENT: _____ **DOB:** _____ **EMAIL:** _____

REGISTRATION FORM

Please fill out all of the boxes requesting information below so we can better serve you!

PATIENT'S NAME: [ ] Dr. [ ] Mr. [ ] Mrs. [ ] Miss. **DEMOGRAPHIC:** [ ] Hispanic/Latino [ ] Not Hispanic or Latino

First: _____ Middle _____ Last _____

If patient is a minor, accompanied by a parent, or
has a legal guardian please list guardian name here: _____

ADDRESS: Street and House Number _____

City _____ State _____ Zip _____

SOCIAL SECURITY NUMBER: _____ **BIRTH DATE:** _____

PHONE (home): (___) ___-____

PHONE (work): (___) ___-____

PHONE (cell): (___) ___-____

EMAIL: _____

Electronic mail will be used for administrative and billing purposes only. You will NOT receive promotional emails from Optometric Associates.

WHAT IS THE BEST WAY TO COMMUNICATE WITH YOU?

[ ] Home Phone [ ] Work Phone [ ] Cell Phone [ ] Email [ ] Snail Mail [ ] Other: _____

Who is your family physician (primary care doctor)? _____

Where is your family physician located? _____

What is your occupation? _____

Who is your employer? _____

What are some of your hobbies (i.e. golf, sewing, cycling)? _____

HOW DID YOU HEAR ABOUT OUR OFFICE?

[ ] Yellow pages / Phone Book
[ ] Penny Saver
[ ] Yelp
[ ] FaceBook
[ ] Website
[ ] Search Engine (i.e. Google, Yahoo)
[ ] Family Physician's Office
[ ] Another Doctor
[ ] Family Member / Neighbor / Friend
[ ] Other: _____

If you were referred to us by another patient at our practice, please share their name below. Nothing is a better compliment to our doctors and staff, and we would like to thank them with a kind note!

Referral Source: _____

When complete, please hand this form and any insurance information to our reception staff. ***Thank you for choosing Optometric Associates.*** *We look forward to serving you! Our doctors and staff will be with you shortly. Feel free to browse our eyewear gallery as you wait.*