Patient Demographics

Last Name: _____ First Name: _____

Middle Initial: _____ Age: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Last 4 Social: _____ Gender: ___ Male ___ Female

Marital Status: Married Widowed Single Divorced Other

Phone: Home: (___)_____ Cell: (___)_____ Work: (___)_____

Occupation: _____ Retired: _____

Student, If Yes: Grade:_____ School: _____

In case of Emergency Who we may Contact?

Name:_____ Relationship:_____ Phone: (___)_____

Referral: Friend:_____ Family:_____ Phone:(___)_____

Medical Insurance:_____

Vision Insurance:_____

Reason for Exam Today: _____

Date of last eye exam: _____ Location: _____

Any eye Injuries in the Past:

When: _____ What Doctor:_____