

First Name _____ Middle Initial _____ Last Name _____

Preferred Name: _____ Birthdate _____ SSN _____

How did you hear about us? _____ Assisted Living Facility _____

Home address: _____

City _____ State _____ Zip code _____

Mailing Address: _____ City _____ State _____ Zip _____

PLEASE LIST THE PHONE NUMBERS & EMAIL WHERE WE CAN REACH YOU:

	Phone number/email	Preferred method of contact	OK to leave a message?
Cell phone	_____	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Home landline phone	_____	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Work phone	_____	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other phone	_____	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Email address*	_____	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No

*Email addresses will be used for you to access your personal health record online, appointment reminders and educational information

PLEASE LIST ANY CONTACTS WE CAN SPEAK TO IN CASE OF EMERGENCY OR REGARDING YOUR HEALTH:

Emergency Contact _____ Relationship to patient _____ Phone _____

Authorized Contact _____ Relationship to patient _____ Phone _____

Referring physician _____ Phone _____

Primary care provider _____ Phone _____

Current eye care provider _____

Preferred Pharmacy _____

BILLING INFORMATION: (person responsible for bill after insurance) Self Workers Comp Other

Name or Company _____ Relationship _____ Phone _____

Address _____

City _____ State _____ Zip code _____

Social history			
Occupation:	<input type="checkbox"/> Student <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/>	Any special needs requiring extra assistance or care?	<input type="checkbox"/> Yes <input type="checkbox"/> No Specify: _____ _____ _____
Company or school:		Preferred Language:	_____
Hobbies:	_____ _____ _____	Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic Partner Spouse name: _____
Living Arrangements:	<input type="checkbox"/> Alone <input type="checkbox"/> Family/Friends <input type="checkbox"/> Assisted Living <input type="checkbox"/> Other:	Which category best describes your race?	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Decline
Are you Hispanic/Latino?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline		

Additional comments:

AUTHORIZATION:

This information provided on this questionnaire is complete and accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment.

Signature of Patient or Authorized Party

Date

Print Name and Relationship (if not patient)

FOR OFFICE USE ONLY	
Reviewed by	Date