Legal Name: _____ Sex M /F SS# _____
(Last) (First) (Middle)

Street Address: _____ Apt. # _____ Date of Birth____/_____/_____

City_____State_____ Zipcode_____Phone Number ( ) _____ -_____

If we can contact you by e-mail, Please fill in your E-MailAddress_____

Employer: _____ Work Phone: _____ Marital Status: M W S D

PREFERRED LANGUAGE (*Circle One*) : English Spanish Other _____
Prefer Not To Answer

RACE (*Circle One*) : White Black Asian Native Hawaiian American Indian
Prefer Not To Answer

ETHNICITY (*Circle One*) : Hispanic Origin Non-Hispanic Origin Prefer Not To Answer

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Parent/ POA/ Legal Guardian_____ Send bills here? Yes or NO

Relationship to patient _____ Responsible party D.O.B. _____/_____/_____

Street Address:_____ Apt#_____

City_____ State_____Zipcode_____ Phone number: ( )_____-_____

Who is your family doctor?_____ Did this doctor refer you here today? Y/N
Do you see a Rheumatologist? _____ Did this doctor refer you here today? Y/N

If an Optometrist referred you here today what is their name? _____Location _____

INSURANCE INFORMATION
(Card copies must be provided to ensure proper claims mailing address)
PLEASE FILL OUT ALL AREAS IN FULL – THIS IS IMPORTANT FOR ELECTRONIC SUBMISSION

	Primary	**Secondary**	**Vision (or Third)**
Insurance Name:	_____	_____	_____
Subscriber Name:	_____	_____	_____
Subscriber Date of Birth:	_____/_____/_____	____/_____/_____	_____/_____/_____
Relationship to insured:	_____	_____	_____
Member/Policy ID#:	_____	_____	_____
Group #:	_____	_____	_____
Employer:	_____	_____	_____

Today's Date:_____

Signature of Patient (if over 18) or Legal Guardian _____