Bryan Vision Associates

Date:

Thank you for choosing our practice for your eye care needs. If you have any questions filling out this form, please ask for assistance. (Please Print)

PATIENT INFORMATION

FIRST NAME:

LAST NAME:

MIDDLE INITIAL:

SALUTATION:

GENDER:

SOCIAL SEC. #:

BIRTH DATE:

AGE:

ADDRESS:

CITY:

STATE:

ZIP:

HOME PH:

WORK PH:
Extension:

CELL:

E-MAIL:

EMPLOYER:

OCCUPATION:

HOBBIES/INTERESTS:

REFERRAL

Who referred you to our office?

Friend or Family Member:

Phonebook/Insurance Co./Website/Other

ADDITIONAL DEMOGRAPHICS

PLEASE NOTE THAT THE FOLLOWING QUESTIONS ARE INCLUDED HERE TO MEET REGULATIONS SET FORTH IN THE NEW HEALTH CARE LAW. WE APPRECIATE YOUR PRIVACY AND YOUR RIGHT OF DECLINING TO ANSWER: (please circle)

RACE:
American Indian
Alaskan Native
Asian
African American
Hawaiian or Pacific Islander
White
Decline to answer

ETHNICITY:
Not Hispanic or Latino
Hispanic or Latino
Decline to answer

PRIMARY LANGUAGE (if other than English):

_____

COMMUNICATION PREFERENCE

BELOW, PLEASE CIRCLE YOUR PREFERRED METHOD OF CONTACT:

Phone: cell home work

Text

E-mail

U.S. Mail

OUR OFFICE USES E-MAIL AND TEXT TO CONTACT PATIENTS – IF YOU WISH TO "OPT-OUT" OF THESE SERVICES PLEASE CIRCLE BELOW:

Opt-out receiving text messages

Opt-out receiving E-mail