PATIENT PROFILE FORM
OPTICARE

IN ACCORDANCE WITH FEDERAL GOVERNMENT REGULATIONS, WE ARE REQUIRED TO OBTAIN THE FOLLOWING INFORMATION. THANK YOU.

PATIENT NAME: _____

ADDRESS: _____

ZIP / CITY / STATE: _____

PRIMARY PHONE: (_____) _____ - _____ □ Home □ Work □ Mobile

SECONDARY PHONE: (_____) _____ - _____ □ Home □ Work □ Mobile

DATE OF BIRTH: [_ _ / _ _ / _ _ _ _]

GENDER: □ Male □ Female

SOCIAL SECURITY #: _____-_____-_____

RACE:
□ American Indian or Alaska Native
□ Asian
□ Black or African American
□ Native Hawaiian/Other Pacific Island
□ White

ETHNICITY:
□ Hispanic or Latino
□ Not Hispanic or Latino

PREFERRED LANGUAGE:
□ English
□ Spanish; Castilian
□ Other-Please note: _____

COMMUNICATION PREFERENCE(S): □ Email □ Mail □ Home Phone □ Mobile Phone

REFERRED BY: □ Patient/Customer □ Doctor/Employee □ Other

NAME OF PERSON WHO REFERRED YOU:

_____

IF OTHER, HOW DID YOU HEAR ABOUT US?

_____