Confidential Patient Information

PAUL VISION INSTITUTE

Thank you for choosing our practice for your eye care needs.

Name _____ **Birthdate** _____

Address _____ **City**_____ **State**_____ **Zip** _____

Home Phone # _____ **Cell #** _____ **Work #** _____

Social Security Number _____ **Male / Female**

Email Address _____

Whom may we thank for referring you to us? _____

Are You: Minor Married Divorced Widowed Single Separated

Employment Status: Retired Full Time Part Time Self Employed Student

Preferred Language:

English

French

Japanese

Spanish

Decline to Specify

Race:

White

Black or African American

Hispanic

Asian

Native Hawaiian /Pacific Islander

American Indian/Alaska Native

Decline to Specify

Ethnicity:

Not Hispanic or Latino

Native Hawaiian/Pacific Islander

Hispanic or Latino

Decline to Specify

Signature _____ **Date** _____