DATE_____
Recorded by_____

Welcome to our practice!

*Thank you for choosing **Rosenthal Optometric** for your eye care needs.*

PATIENT INFORMATION-PLEASE PRINT

Patient Name _____ **Birthdate** _____
First **MI** **Last**
I prefer to be called_____ □ Male □ Female **Social Security#**_____

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

Home phone # _____ **Cell/Other phone #**_____

Preferred method of contact: □ cell phone □ home phone □ text □ Email_____

(We do not share your information. E-Mail addresses are used for information directly from our office and for appointment scheduling & confirmation.) **We have an automated system that will remind you of your upcoming appointments! The system can text, call your home phone and email you! Please make sure, to check appropriate box of preferred method of contact.**

Are you: □ Single □ Married □ Divorced □ Separated □ Widowed

Your employer _____ **Occupation** _____

Whom may we contact to discuss your medical care_____ **Phone #** _____

Pharmacy_____**City**_____

Primary Medical Doctor _____**City**_____

Circle which applies:

Preferred Language: English/ Spanish, or Other_____
Race: White, American Indian or Alaska Native, Asian, Black or African American, Hispanic, Native Hawaiian/Other Pacific Islander
Ethnicity: Hispanic or Latino, Native Hawaiian/Other Pacific Island, or Other

RESPONSIBLE PARTY & INSURANCE INFORMATION

Please present all insurance cards at reception desk

Name of policyholder/Person responsible for this account_____

Relationship to patient_____ Birthdate _____ Social Security #_____

Address _____ City _____ State _____ Zip _____

Home phone #_____ Work phone # _____ Cell # _____

Responsible party's employer _____Occupation_____

_____ _____

Signature of Insured/Guardian **Date**