**CONFIDENTIAL**

# Claremore - Pryor Eye Clinic, P.A.

David Reinecke, M.D. Eric Lynn, O.D.

Date: _____

*How were you referred to our office? Friend or Relative (Please name)* _____

Patient's Name _____
Last Name First Name M. Initial Nickname

Sex: ☐ M ☐ F Salutation: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Other _____ Date of Birth _____ Age _____

Address _____ City _____ State _____ Zip _____

Country _____ Address Type: ☐ Mailing ☐ Legal ☐ Other

Communication Preference: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ E-mail

Home Phone (___) _____ Work Phone (___) _____ Ext. _____

Cell Phone (___) _____ Carrier _____

E-mail _____

Social Security # _____ Drivers License # _____

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other

Primary Language _____ Special Needs _____

Race _____ Ethnicity: ☐ Non-Hispanic ☐ Hispanic/Latino ☐ Unknown ☐ Declined to Answer

Occupation _____ Employer _____

Birth State _____

Emergency Contact Person _____
(Not living in your household)

Daytime Phone (___) _____ Relationship _____

**If form is being completed for a dependent, please complete the following information:**

Father's Name _____ Social Security # _____

Address (If different from patient) _____

Employer _____ Business Phone (___) _____

Birthdate _____ Cell Phone (___) _____

Mother's Name _____ Social Security # _____

Address (If different from patient) _____

Employer _____ Business Phone (___) _____

Birthdate _____ Cell Phone (___) _____