# NEW PATIENT QUESTIONNAIRE

**Date** _____

**Patient ID#**_____

## GENERAL INFORATION

| | | | | | |
|---|---|---|---|---|---|
| Name: First, MI, Last | | | | Nickname: | |
| Street Address | | | | | |
| City, State, Zip | | | | | |
| Date of Birth | | | | | |
| Patient Social Security Number | | | | | |
| Gender (circle) | Male | Female | | | |
| Language, Race, Ethnicity | | | | | |
| Phone # | Home | | Cell | Work | |
| Preferred Contact Method (Circle) | Cell | Email | Text | Other | |
| Email | | | | | |
| Occupation/Employer | | | | | |
| Marital Status (Circle) | Married | Single | Divorced | Legally Separated | Widowed |
| Emergency Contact Person | | | | Phone: | |
| Hobbies | | | | | |

## INSURANCE INFORMATION

| | | | |
|---|---|---|---|
| **VISION INSURANCE** | | | |
| Vision Insurance Name | | | |
| Member/ Policy Holder | | | |
| Member ID# | | | |
| Member Date of Birth | | | |
| Your Relationship to Primary Member (Circle) | Self | Spouse | Child |
| **PRIMARY MEDICAL INSURANCE** | | | |
| Primary Medical Insurance Name | | | |
| Member Name | | | |
| Insurance ID# | | | |
| Insurance Policy #/Group ID# | | | |
| Primary Member Date of Birth | | | |
| Primary Member Social Security Number | | | |
| Primary Member Employer | | | |
| Your Relationship to Primary Member (Circle) | Self | Spouse | Child |
| **SECONDARY MEDICAL INSURANCE** | | | |
| Secondary Medical Insurance Name | | | |
| Member Name | | | |
| Insurance ID# | | | |
| Insurance Policy #/Group ID# | | | |
| Member Date of Birth | | | |
| Member Social Security Number | | | |
| Your Relationship to Primary Member (Circle) | Self | Spouse | Child |

## SOCIAL HISTORY – Circle appropriate answer

| | | | | | |
|---|---|---|---|---|---|
| Do you drive? | Yes | No | If yes, do you have visual difficulty when driving | Yes | No |
| | | | If yes, please describe: | | |
| Do you drink Alcohol? | Yes | No | | | |
| Do you currently use tobacco products? | Yes | No | Have you in the past? | Yes | No |
| Do you use illegal drugs? | Yes | No | | | |
| Does the patient have any learning or behavioral disabilities? Please explain. | | | | | |