

DR. LAURA ANNE POTVIN, P.C.
OPTOMETRISTS

DATE: _____

LAST NAME: _____ FIRST NAME: _____

NICKNAME: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____

MAY WE TEXT YOU? Y N

WORK PHONE: _____ MAY WE CALL YOU AT WORK? Y N

E-MAIL ADDRESS: _____ PREFERRED COMMUNICATION:

REFERRED BY: _____ EMAIL PHONE POSTAL

SEX: M F DATE OF BIRTH: _____ MARITAL STATUS: M W D S

SOCIAL SECURITY NUMBER: _____ OCCUPATION: _____

EMPLOYMENT STATUS: _____ EMPLOYER: _____

RACE: Native American/Native Alaskan ETHNICITY: Hispanic/Latino

Asia Native Hawaiian

Black/African American Other Pacific Island/Asian

Hispanic Not Hispanic/Latino

White

Native Hawaiian/Other Pacific Island

LAST EYE EXAM: _____ DOCTOR: _____