KENNEDY
VISION HEALTH CENTER

First Name: _____ MI: _____ Last Name: _____ □ Male □ Female

Address: _____ City:_____State:_____ Zip: _____

DOB: _____/_____/_____ Age: _____ Social Security # (or last 4 #s): _____

Cell Phone Number: _____ -_____-_____ Home Phone Number: _____ - _____-_____

Work Phone Number: _____ - _____-_____ Email Address: _____

Emergency Contact:_____ Relationship:_____ Phone: _____

Preferred Contact (Please select one): □ Cell Phone □ Home Phone □ Work Phone □ Email □ Text

May we contact you via email? □ Yes □ No **May we contact you via text message?** □ Yes □ No

Race: □ Caucasian □ African American □ Asian □ Hispanic □ Indian □ Other _____

Preferred Language: □ English □ Other _____

How did you hear about our office?

□ Existing Patient (Name) _____

□ Insurance Company □ Website □ Newspaper Ad □ Drive By □ BNI □ Direct Mailing

□ Family or Friend (Name): _____ (We would like to thank them)

□ Other: _____

Name of Primary Medical Insurance: _____

Name of Insurance Policy Holder? □Self □Other: _____ DOB: ____/_____/_____

Do you have separate Vision Insurance (VSP, EyeMed)? □ Yes □ No
(Name of Vision Insurance) _____