EYE PHYSICIANS OF AUSTIN
Advanced Eye Care

Patient Information

(PLEASE PRINT)

Patient's Name	**Social Security #**	**Marital Status** **S M W D**	**Sex** **M F**	**Date of Birth**
Patient's E-mail Address	**Home Phone #** **( ) -**	**Cell Phone #** **( ) -**	**Work Phone #** **( ) -**	
Ethnicity **Not Hispanic or Latino Hispanic or Latino Unknown**	**Race** **American Indian/ Asian/ African American/ White/ Other**		**Primary language**	
Street Address	**City, State, Zip Code**			
Mailing Address **(If different from above)**	**City, State, Zip Code**			
Patient's Employer	**Occupation (Indicate if Student)**			
Spouse or Parent's Name	**Social Security #** **Birthdate**			
Spouse or Parent's Employer	**Occupation (Indicate if Student)**			
Person Responsible for Payment **(If different than above party)**	**Street Address, City, State, Zip Code**			
	Home Phone # **( ) -**	**Work Phone #** **( ) -**		

Present Glasses-How old are they?_____

Do You wear Contacts? Y N

Do you have an Optometrist?____ If so, who?_____

Who is your Primary Care Physician?_____

Who referred you to our office?_____

How would you like us to communicate with you? Circle all that apply

Email Text Phone Call
