THE OFFICE OF
DR. DAWN RAKICH, OPTOMETRIST
CONFIDENTIAL PATIENT INFORMATION

Date ____/____/____

Dr. Mr. Mrs. Ms. Miss _____ Male Female

Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Cell Phone/Pager: _____

Work Phone: _____ Email: _____ Marital Status: _____

Age: _____ Date of Birth: _____/_____/_____ SS #: _____-_____-_____ Driver's License #: _____

Employer: _____ Occupation: _____

Spouse's Name: _____ Occupation: _____

Cell Phone: _____ Work Phone: _____ Employer: _____

Primary Care Physician: _____ Date of Last Visit: _____

Referred by: Phone Book Insurance School Drive By Advertisement Patient _____
Doctor _____ Other _____

If patient is a child or adolescent, please complete the following:

Parent/Legal Guardian: _____ Occupation: _____

Cell Phone: _____ Work Phone: _____ Employer: _____

Child's School: _____ Grade: _____

Other family members, still living at home:

Name_____ Age_____ Name_____ Age_____

Name_____ Age_____ Name_____ Age_____

Name_____ Age_____ Name_____ Age_____

Primary Medical Insurance: _____ **Phone #:** _____

Name of Policy Holder: _____ Relationship to Patient: _____

Policy Holder Date of Birth: _____ Employer: _____ PCP Referral Required? Yes No

Policy #: _____ Group #: _____ PCP: _____

Vision Plan Insurance: _____