EYECARE & EYEWEAR CENTER OF MAINE

Douglas Gauvreau, O.D. Eric Roush, O.D. Jennifer Haverkamp, O.D.

PATIENT DEMOGRAPHIC FORM

PLEASE FILL IN ALL INFORMATION
(This information is required by new federal regulations)

(circle one): Mr. Mrs. Ms. Miss Master Dr. Prof. Rev. Sister

NAME: _____ SUFFIX: ____

DOB: _____ **AGE:** _____ (circle one): Male Female Other Not Specified

STREET: _____

CITY:_____ **STATE**:_____ **ZIP CODE**:_____

SSN (patient's social security number) _____

COMMUNICATION:

PREFERENCE CALL (circle one) home cell work e-mail

HOME PHONE: _____

CELL PHONE: _____

WORK PHONE:_____

E-MAIL:_____

PRIMARY LANGUAGE: _____

RACE: (circle one): American Indian or Alaskan, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, White, Decline to answer

ETHNICITY (circle one): Hispanic or Latino not Hispanic or Latino Decline to answer

MOTHER'S MAIDEN NAME: _____

BIRTH STATE _____

Primary Medical Care Doctor: _____ Town: _____