



Laura L. Harris, M.D., F.A.C.S.

PATIENT INFORMATION					DATE: ___/___/___		
Last Name		First	MI	Date of Birth / /		Age	Sex
Street Address			City	State	Zip	Social Security Number	
Home Phone		Work Phone		Cell Phone		E-mail Address	
Employer			Employer Address		Occupation		
Martial Status: (Circle One) Single Divorced Widowed Married Separated Minor							
Spouse's Name			Spouse's Date of Birth / /		Spouse's Social Security Number		
Emergency Contact Name			Relationship		Emergency Contact Phone		
REFERRED BY:							
Optometrist: (Full Name)				Optometrist Phone: (If Known)			
Pharmacy Name				Pharmacy Phone			
Primary Physician: (Full Name)				Primary Physician Phone: (If Known)			
INDIVIDUAL RESPONSIBLE FOR PAYMENT PLEASE FILL OUT IF DIFFERENT THAN PATIENT							
Last Name		First	MI	Date of Birth / /		Relationship	
Street Address			City	State	Zip		
Home Phone		Work Phone		Cell Phone		Social Security Number	
Employer							