



3670 SOUTH BENZING RD • ORCHARD PARK, NEW YORK 14127  
(716) 662-5357 • FAX (716) 662-2774

**PATIENT INFORMATION**

\_\_\_\_\_  
(Print Patient Name)

\_\_\_\_\_  
(Date of Birth)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(Preferred Contact Phone #)  
 Cell       Home

\_\_\_\_\_  
(City, State & Zip Code)

\_\_\_\_\_  
(E-mail Address)  
 I would NOT like to subscribe to OPFP eNewsletter

**Gender**     Male    Female                       **Social Security Number** \_\_\_\_\_

**Marital Status**             Annulled                       Divorced                       Domestic Partner  
 Legally Separated     Married                       Widowed  
 Never Married/Single

**Voluntarily, self-identified race**     White     Black/African American     Asian  
 Native Hawaiian/Pacific Islander     Other

**Voluntarily, self-identified ethnicity**     Spanish/Hispanic Origin  
 Not of Spanish/Hispanic Origin  
 Unknown

**Language Preference**     English     Spanish     French     Other

**If under 18, Mother's Maiden Name** \_\_\_\_\_

Responsibility Party \_\_\_\_\_

Address \_\_\_\_\_

**Do You Have Hearing Impairment?**     Yes    No  Details: \_\_\_\_\_

**Do You Have Vision Impairment?**     Yes    No  Details: \_\_\_\_\_