**Patient Registration**

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| --- |
| Name: Gender: M F |
| Mailing Address: |
| City: |
| State: Zip: |
| Home Phone: (Can we leave a message) Y N  |
| Daytime Phone (if different): (Can we leave a message) Y N  |
| Cell Phone: (Can we leave a message) Y N  |
| E-Mail Address: |
| Referred By: |

|  |
| --- |
| Date of Birth: |
| Social Security Number: |
| Marital Status: |
| Employment Status: |
| Employer: |
| Occupation: |
| Race: (circle one) |
|  **White Polynesian American Indian/Alaskan/Inuit** |
|  **African American Hispanic Asian** |
| Last Eye Exam: Eye Doctor: |
| Insurance Subscriber Name:  |
| Insurance Subscriber Date of Birth: |

By completing this form, I give Dr. Visser-Robel and Dr. Pearson permission to treat, within their scope of practice, myself or my minor child.

Patient Name: Date: