New Patient Registration

All information contained within this form is strictly confidential.
Please complete this document prior to your first appointment.

Adult Form

Patient Information

First Name ______________________

Last Name ______________________

Middle Initial ________ Gender ______________

Birth Date ____________ SSN ______________

Home Address ______________________

Suite/Apt. ______________________

City ________ State __________ Zip Code ________

(Please mark preferred)

☐ Cell # ______________________

☐ Home # ______________________

☐ Work # ______________________

E-Mail ______________________

Occupation ______________________

Employer/School ______________________

Relationship Status

☐Single ☐Divorced

☐Married ☐Widowed

Spouse's Name ______________________

Spouse's Employer ______________________

Race (Optional)

☐American Indian or Alaskan Native ☐Black or African American ☐Asian

☐Native Hawaiian or Other Pacific Islander ☐White or Caucasian ☐Decline

☐Other ______________

Ethnicity (Optional)

☐ Hispanic or Latino ☐ Decline

☐ Not Hispanic or Latino

Preferred Language ______________

Reason for Visit

Date of last eye exam ______________ Former Optometrist ______________

What is your main reason for visit? ______________________

Are you interested in LASIK or any other type of refractive surgery? ☐Yes ☐No

Do you experience difficulty seeing in dim/dark environments with tasks such as reading or driving? ☐Yes ☐No

Do your eyes itch, burn, water, or feel as if there is sand or grit in them? ☐Yes ☐No

Insurance Policy Holder Information

Vision Insurance Provider ______________________

Medical Insurance Provider ______________________

Policy Holder Name ______________________

Member's Date of Birth __________ Member's SSN __________

Member's Phone # ______________ ☐Cell ☐Home ☐Work

Member's Address (if different from above):

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Where did you hear about our office?

☐ Referred by your doctor

☐ Visited our website

☐ Found us on social media

☐ TV Commercial

☐ Printed Publication

☐ Referred by ______________

☐ Other ______________

Thank you for choosing Family Focus Eyecare!