HATTORI VISION PATIENT REGISTRATION

Dr / Mr / Mrs / Miss / Ms _____ Today's Date_____

Nickname_____ Birth Date_____

Home Address:

_____

_____

_____

Mailing Address (if different):

_____

_____

_____

Home Phone:_____ Business Phone:_____

E-Mail Address:_____ Cell Phone:_____

Occupation:_____ Employer:_____

Spouse's Name:_____ Spouse's Employer:_____

Children: Name Age

(living at home) _____ _____

_____ _____

Payment is due at the completion of the examination and/or on delivery of material.

Bill Payer: (if other than self)

Name:_____ Relationship:_____

Address:_____ Telephone:_____

Insurance: (Please give the front desk any forms or insurance cards)

Vision:_____ Medical:_____

Social Security #:_____

I authorize payment of benefits to Hattori Vision. I also understand that any recommended, additional procedures will be billed to my medical insurance, and that I will be responsible for any fees not covered by my insurance within 90 days.

_____

(*Signature*) **(*Date*)**

Are you interested in discussing contact lenses? ☐ Yes ☐ No ☐ Already wear

Do you work on a computer more than 3 hours a day? ☐ Yes ☐ No

Are you interested in discussing refractive therapy / surgery? ☐ Yes ☐ No

If you are a new patient, whom may we thank for referring you to us?_____

Reviewed: _____ Date: _____ Reviewed: _____ Date: _____

Initials Initials

Reviewed: _____ Date: _____ Reviewed: _____ Date: _____

Initials Initials