HATTORI VISION STUDENT REGISTRATION

Mr / Miss		Today's D	ate	
Nickname		Birth Date		
Home Address:				
Home Phone:	School/Grac	le:		
E-Mail Address:	Cell Phone:			
Mother's Name:	Father's Na	me:		
Work Phone:	Work Phone:			
Cell Phone:	Cell Phone:		· · · · · · · · · · · · · · · · · · ·	
Employer:	Employer:			
Name:	s or insurance Medica	one: cards) l: nderstand f nce, and that	hat any reco at I will be res	mmended, sponsible for
(Signature of Parent or Guardian)			(Dat	(e)
Are you interested in discussing contact lenses?		Yes	No	Already wear
Do you work on a computer more than 3 hours		Yes	No	
Are you interested in discussing refractive thera If you are a new patient, whom may we thank for		Yes uto us?	No	
Reviewed: Date: Initials		Reviewed:	Date:	
Reviewed: Date: Initials		Reviewed:	Initials	