



PIEDMONT *: Registration Sheet*

better vision

Patient Name _____

How would you like to be addressed? _____

Date of Birth ____ / ____ / ____ Male Female | Married Single

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Mobile Phone _____

E-Mail Address (*please print*) _____

Last 4 digits of Social Security Number : ____ ____ ____ ____ (*for laser ID only*)

Occupation _____

Employer _____

Hobbies/Activities _____

Name of emergency contact NOT living with you _____

Relationship _____

Home Phone _____ Work Phone _____

Referred by _____

Who provides your routine eye care? _____

This authorization remains in effect unless revoked by me in writing:

I hereby agree that I am personally responsible for all charges for services rendered.

PATIENT SIGNATURE _____ Date _____