PIEDMONT
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_____