SEDONA EYE CARE

Patient Registration

Name:(Mr. Mrs. Ms.)_____Birthdate:_____Sex M F

Address:_____ City_____State_____ Zip_____

Phone: Home:_____ Daytime:_____ Cell:_____
Text ____Yes ____ No

Email:_____

Communication Preference: Email Postal Telephone

Social Security:_____ Marital Status: Married Single Divorced Widowed

Employment Status: Full Time Part Time Self Employed Retired Student

Preferred Language: English Spanish

Race: American Indian Asian African American Hispanic Native Hawaiian White

Occupation:_____ Employer:_____

Referred By:_____

Doctor/Nurse practitioner :_____

Do you have Medicare? YES NO

ANY CONCERNS FOR TODAY'S VISIT

Date:_____Concern:_____

Date:_____Concern:_____

Date:_____Concern:_____

Date:_____Concern:_____

Per HIPPA regulations review and update every 6 months:

Initial:_____ Date:_____

Initial:_____ Date:_____

Initial:_____ Date:_____

Initial:_____ Date:_____