ADULT REGISTRATION FORM

DATE: ____________________

Patient's Name: ____ Preferred Name: ______________________
Last *First* *MI*

DOB: _______/_______/________ Birth Sex: ☐ Male ☐ Female Gender Identification:________________
MM DD YYYY

Marital Status: _______________ Social Security Number (last four minimum): ___________________________

Mailing Address: ____
Street *City* *St* *Zip*

Phone Numbers: ____
Preferred Phone (Check box) *☐ Home* *☐ Cell* *☐ Work*

E-Mail address: ____________________________________ Referred by: _____________________________________

Would you like to receive electronic reminders of upcoming appointments? ☐ Yes ☐ No

How did you hear about Washington Vital Vision? (Check box below)

☐ Radio ☐ Newspaper ☐ Friends/Family ☐ Web Search ☐ Flyers ☐ Other: ___________________

ARE YOU IN A SKILLED NURSING FACILITY? ☐ Yes ☐ No If Yes, NAME:_____________________________

Employer: ____Employer Phone: _______________________

Emergency Contact: ____ Relationship: ___________________________
Last *First*

Phone Number: _________________________ Phone Type: ☐ Home ☐ Cell ☐ Work

Insurance Information:

Primary Insurance: ____ Effective Date: __________________

Policy Holder's Name: ___________________________________ DOB: ____________ Relationship: ______________

Secondary Insurance: ____ Effective Date: __________________

Policy Holder's Name: ___________________________________ DOB: ____________ Relationship: ______________

Vision Plan: ____ Effective Date: ______________________

Policy Holder's Name: ___________________________________ DOB: ____________ Relationship: ______________

ID # (if insurance card not issued):______________________________