LIFESTYLE EYE CENTER
Healthy You – Healthy Eyes

1610 Penny Ln
Walla Walla, WA 99362-4477
ph: (509) 540-3937
fx: (509) 540-3938
www.LifestyleEye.com

PATIENT REGISTRATION FORM

First Name _____ **Middle Initial** _____ **Last Name** _____

Preferred Name: _____ **Birthdate** _____ **SSN** _____

How did you hear about us? _____ **Assisted Living Facility** _____

Home address: _____

City _____ **State** _____ **Zip code** _____

Mailing Address: _____ **City** _____ **State** _____ **Zip** _____

PLEASE LIST THE PHONE NUMBERS & EMAIL WHERE WE CAN REACH YOU:

	Phone number/email	Preferred method of contact	OK to leave a message?
Cell phone		❑	❑ Yes ❑ No
Home landline phone		❑	❑ Yes ❑ No
Work phone		❑	❑ Yes ❑ No
Other phone		❑	❑ Yes ❑ No
Email address*		❑	❑ Yes ❑ No

*Email addresses will be used for you to access your personal health record online, appointment reminders and educational information

PLEASE LIST ANY CONTACTS WE CAN SPEAK TO IN CASE OF EMERGENCY OR REGARDING YOUR HEALTH:

Emergency Contact _____ **Relationship to patient** _____ **Phone** _____

Authorized Contact _____ **Relationship to patient** _____ **Phone** _____

Referring physician Dr. _____ **Phone** _____

Primary care provider Dr. _____ **Phone** _____

Current eye care provider Dr. _____

Preferred Pharmacy _____

BILLING INFORMATION: (person responsible for bill after insurance) ❑ Self ❑ Workers Comp ❑ Other

Name or Company _____ **Relationship** _____ **Phone** _____

Address _____

City _____ **State** _____ **Zip code** _____

Please initial this page _____

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Social history			
Occupation:	❑ Student ❑ Retired ❑ Disabled ❑	**Any special needs requiring extra assistance or care?**	❑ Yes ❑ No Specify: _____ _____ _____
Company or school:		**Preferred Language:**	_____
Hobbies:	_____ _____ _____	**Marital Status:**	❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Domestic Partner Spouse name:_____
Living Arrangements:	❑ Alone ❑ Family/Friends ❑ Assisted Living ❑ Other:	**Which category best describes your race?**	❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Decline
Are you Hispanic/Latino?	❑ Yes ❑ No ❑ Decline		

Additional comments:

_____

_____

_____

AUTHORIZATION:

This information provided on this questionnaire is complete and accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment.

_____ _____

Signature of Patient or Authorized Party **Date**

_____

Print Name and Relationship (if not patient)

FOR OFFICE USE ONLY	
Reviewed by	Date

Please initial this page _____