Shoreline Vision
Vision Care. For Life.®

REGISTRATION FORM

Patient Information

Date:_____

Legal First Name:_____ Last Name: _____
Middle Name:_____ Nickname/Preferred First Name:_____
Marital Status: Married____ Single____ Divorced_____ Widowed_____ Legally Separated_____
Social Security Number:_____ Date of Birth:_____ Sex: M / F
Billing Address:_____
City, State, Zip:_____
Home Phone: (_____)_____Day Phone: (_____)_____Cell Phone: (____)_____
Email:_____
Emergency Contact: _____Relation: _____ Phone: _____
2nd Emergency Contact: _____ Relation: _____ Phone: _____
Preferred Method of Contact: Home Phone_____ Day Phone_____ Cell Phone____ Email_____ Portal_____ Text _____
Patient Resides in Nursing Home/ Care Facility: Y / N
Primary Care Physician:_____ Referring (if different):_____

Race:

- ◯ American Indian or Alaskan Native
- ◯ Asian
- ◯ Black or African American
- ◯ Declined
- ◯ Hispanic or Latino
- ◯ Native Hawaiian or Other Pacific Islander
- ◯ White

Spoken Language:

- ◯ English
- ◯ Spanish
- ◯ Russian
- ◯ Other:_____
- ◯ Interpreter Needed
- ◯ Sign Language Interpreter Needed

Employment:

Student_____ Retired _____ Full Time _____ Part Time _____ Laid Off_____
Employer Name: _____
Employer Address: _____

Responsible Party (Must be completed for Minors)

Full Name of Cardholder or Guardian:_____ DOB:_____
Social Security Number:_____ Sex: M / F Relationship to Patient:_____
Complete Street Address (if different):_____
Home Phone:(_____)_____ Day Phone:(_____)_____ Cell Phone:(_____)_____