# 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: _______________________

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: ________________________________________________________________________________

Employee 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:(_____)_______________

## HIPAA:

I authorize Shoreline Vision to disclose my protected health information (PHI) and billing information to:

Name: ____________________________________________ Relationship: ______________________________________

Patient Signature: _______________________________________________________________________________

Responsible Party Signature: ______________________________________________________________________