HORIZON EYE SPECIALISTS & LASIK CENTER

PATIENT REGISTRATION SHEET

_____
FIRST M.I. LAST

Social Security Number: _____ Date of Birth: _____

Primary Phone: _____ ☐ Mobile ☐ Home ☐ Work

Secondary Phone: _____ ☐ Mobile ☐ Home ☐ Work

Address: _____ City: _____

State: _____ Zip Code: _____ Email: _____

Birth Gender:_____ Marital Status:_____

Family Physician: _____ Phone Number: _____

Referred By: _____

Patient's Employer: _____ Occupation: _____

Person to Notify in Case of Emergency: _____ Relationship: _____ Phone: _____

Person Responsible for Payment of Account (if different from above): _____
Address (if different from above): _____ City: _____State: ____ Zip: _____

_____ ***I give my consent for Horizon Eye Specialists to leave voicemail messages on my preferred phone number.***
Initials

Patient Signature: _____ Date:_____

Horizon Eye Specialists & Lasik Center, 18325 N Allied Way, Suite 100, Phoenix, AZ 85054
Office Number: (602) 467-4966 Fax Number: (480) 419-5401