Patient Registration Form

PLEASE Print Clearly

First Name: _____ Last Name: _____

Your Address: _____ City: _____

State: _____ Zip: _____

Date of Birth: _____ Occupation: _____

Height: _____ Weight: _____ Gender: Male Female

Home Phone Number: _____

Cell Phone Number: _____

Secondary Phone Number (Work, Ect.): _____

E-Mail: _____

Referring Professional: _____

How Did You Hear About Us: * Doctor *Friend/Family *Website *Yellow Pages *Facebook *Other

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Parent/Guardian/Contact **(If Applicable)**

Contact First Name: _____ Contact Last Name: _____

Contact Phone Number: _____

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Are You Diabetic: Yes No

Chief Complaint: _____

Do You Require a Private Fitting Room: Yes No

Name of person who can pick up your records: _____

Please Provide Your Insurance cards so we can make a copy for your file

NOTE: In an addition you will be asked to sign a HIPAA Privacy act and a Consent Form.