BALDWIN OPTICAL
Patient Registration

____
Today's Date

First Name Middle Last

Address (P.O. Box & Street)

City State Zip

Birth Date Age Sex (M/F)

Phone Number Work Phone Number

E-mail Address

May we leave a message for you? Y _____N ____

How we may contact you: Home/ Cell ____ Work ____ E-mail____

Insurance Company Member ID Number

If you have VSP: ____
Who is the primary insured DOB What are the last four digits of the primary's SSN

What is the main reason for your visit today? ___________________________________

If you need a correction, do you want: ____ glasses ____contacts ____ Laser Vision

____ **Date:** ____________________
Responsible Party's Signature (Sign & Print Name)