



Patient Registration

Please complete all the information below

Name: Last		First	Middle	Social Security Number		Doctor	
Home Address:			(Apt)	Preferred Name		Occupation	
City		State		Zip		Employer	
Home Phone:		Business Phone:		Employer Street Address			
Cell Phone:				City		State Zip	
Date of Birth		Sex	Marital Status		Spouse Name		Spouse Business Phone
Emergency Contact – Other than Spouse				Patient e-mail address			
Name: Last		First		Are you from outside metro Atlanta? Where do you plan to stay?			
Home Phone		Business Phone		Atlanta Address (hotel, friend, etc.)			
Relationship				Atlanta Phone			
Activities and Interests Recommendations for surgery depend upon visual needs. What are your activities and interests?				What main source influenced your decision to choose Emory Vision?			
<ul style="list-style-type: none"> • Golf • Tennis • Biking • Skiing • Dancing • Family/Kids • Movies • Books/ Reading 		<ul style="list-style-type: none"> • Running/walking • Dining Out • Gardening • Theatre • Museums/The Arts • Travel • Other (please specify) 		<ul style="list-style-type: none"> • Referring doctor (name?) _____ • Emory Vision patient _____ • Emory employee _____ • Friend/Family _____ • Internet Source: _____ • Newspaper _____ • Magazine _____ • Radio _____ 			
Where do you currently obtain your eye care? _____				<ul style="list-style-type: none"> • Television What show/ station? _____ • Other _____ 			
Date of last exam? _____							

Authorization for Release of Information

I hereby authorize Emory Vision to release any medical information to my referring physician or insurance company. I further understand that I can withdraw this consent for release of information at any time prior to this expiration date except to the extent that action has been taken in reliance hereon.

I hereby authorize the use of data from my visual examinations/measurements performed at Emory Vision for scientific publication and research. I understand that my data will remain confidential as it will be pooled with the data of other patients and my name will not be used at any time.

Signature: _____

Date: _____