



**VISTARR™**  
LASER & VISION  
CENTERS

Date: \_\_\_\_\_

New

Update

## Patient Registration

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Social Security No. \_\_\_\_\_ Sex M F Marital Status \_\_\_\_\_

### Responsible Party/Primary Insurance Subscriber: (if other than patient)

Subscriber Name \_\_\_\_\_ Subscriber Social Security # \_\_\_\_\_

Subscriber Date of Birth \_\_\_\_\_ Relationship \_\_\_\_\_

Address (if different from above) \_\_\_\_\_

### Insurance Information: (Please present card(s) to receptionist)

Primary Insurance Company Name \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_

Secondary Insurance (if applicable) \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_

### Subscriber Employment Information:

Employer \_\_\_\_\_ Phone \_\_\_\_\_

Employer Address \_\_\_\_\_

### Do you have a vision plan? (Examples: Davis Vision, Cole Vision, VSP, Blue Shield)

Name of Vision Plan \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_