BRENNER EYE & FACIAL CENTER

NEW PATIENT REGISTRATION SHEET

Name:			Today's Date:
Home Phone:	Cell Phone:	Work Phone:	
Address:			
City:	State:	Zip:	
Date of Birth:	Social Security Number:	Gender: M F	
Drivers License #:	Sate:	Marital Status: Single Married Widowed Divorced	

Referred By:	☐ Friend/Family:	☐ Website:
	☐ Newspaper:	☐ Other:
Spouse or Significant Other:		Phone:

Employer:	Address:	
City:	State:	Zip:
Occupation:		Retired:

Insurance: Please list the subscriber of the policy if other than the patient. List your primary insurance company first.

Primary:	Policy #
Address:	Group #
Subscriber:	
Secondary:	Policy #
Address:	Group #
Subscriber:	

Email: To help us server you better – please enter your current email address below:

Note: We keep all patient information strictly confidential. Your address is never shared.

Would you like to receive newsletters about advancements in eye care, anti-aging & facial aesthetics?

☐ Yes ☐ No

Are you interested in LASIK to get rid of your glasses or contact lenses?

☐ Yes ☐ No

Would you like to decrease your dependency on reading glasses?

☐ Yes ☐ No

Are you interested in reducing the lines on your face using BOTOX and/or fillers (Radiesse or Juvéderm)

☐ Yes ☐ No