

**H E A L I N G  
T H E  
E Y E**

**& Wellness Center**

Dr. Edward C. Kondrot, MD (H), CCH, DHt.  
2001 W Camelback Rd Suite 255  
Phoenix, AZ 85015

**PATIENT REGISTRATION FORM**  
**PLEASE PRINT**

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SOCIAL SECURITY #

\_\_\_\_\_  
LAST NAME

\_\_\_\_\_  
FIRST NAME

\_\_\_\_\_  
M.I.

\_\_\_\_\_  
STREET ADDRESS

\_\_\_\_\_  
CITY

\_\_\_\_\_  
STATE

\_\_\_\_\_  
ZIP

\_\_\_\_\_  
DAYTIME PHONE

\_\_\_\_\_  
EVENING PHONE

\_\_\_\_\_  
OTHER PHONE

\_\_\_\_\_  
MALE

\_\_\_\_\_  
FEMALE

\_\_\_\_\_  
AGE

\_\_\_\_\_  
BIRTHDATE

\_\_\_\_\_  
IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED?

\_\_\_\_\_  
PHONE NUMBER

MAY WE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE REGARDING YOUR  
CARE AT HEALING THE EYE & WELLNESS CENTER?

YES

NO

PLEASE INITIAL \_\_\_\_\_

[www.healingtheeye.com](http://www.healingtheeye.com)

1.800.430.9328



PLEASE LIST ANY OTHERS (i.e. SPOUSE OR FAMILY MEMBERS) TO WHOM WE MAY RELEASE YOUR PRIVATE HEALTH INFORMATION

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NAME	PHONE	RELATIONSHIP
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PATIENT EMPLOYED BY	OCCUPATION
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BUSINESS ADDRESS	BUSINESS PHONE
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PERSON RESPONSIBLE FOR ACCOUNT	RELATIONSHIP
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ADDRESS (if different from patient's)	PHONE
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WHOM MAY WE THANK FOR REFERRING YOU?

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PRIMARY REASON/COMPLAINT FOR SEEING THE DOCTOR

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SIGNATURE (Patient or Guardian)

DATE

