

Valley Vision Associates

Robert Davis, OD
Erick Johnson, OD
Abel Li, MD

Daniel Hanson, MD
Emily M. Korszen, OD
Scott Oltman, OD

PATIENT INFORMATION

Last Name _____ First Name _____ MI _____

Mailing Address _____ Apartment Number _____

City _____ State _____ Zip _____

Date of Birth _____ Employer _____ Occupation _____

Home Phone (____) _____ Work Phone(____) _____

Cell Phone (____) _____ E-Mail _____

SSN (only if needed for billing insurance) _____

**For communication purposes, would you prefer to be contacted via phone, email, or text?
Please circle one or more.*

Phone

E-Mail

Text

For billing purposes, please provide a current mailing address and phone number (if different from above) for the **responsible party that will be billed for today's visit.**

Name _____ Relationship to patient _____

Mailing Address _____ Date of Birth _____

City _____ State _____ Zip _____

Phone Number (____) _____