

Patient Registration Form

Please use Black Ink only to fill out forms.

Please check this box if you are a winter visitor. If so, please provide both addresses.

Mr. Mrs. Ms. Male Female

LEGAL Name:

Last

First

MI

Marital Status: _____

Age: _____ Date of Birth ____/____/____ Social Security # _____

Local Address:

Street

Apt#

City

State

9 DIGIT ZIP

Mailing Address:

Street

Apt#

City

State

9 DIGIT ZIP

RACE: American Indian or Alaska Native Asian Black or African American
 Native Hawaiian or Other Pacific Islander White Unknown Other _____
 Refuse

PRIMARY LANGUAGE: English Spanish Other _____ Refuse

ETHNICITY: Hispanic or Latino Non-Hispanic or Non-Latino Unknown Refuse

MEDICAL INFORMATION: Who is your Medical Doctor? _____

Address: _____ Phone _____

Your Home Phone: _____ Cell Phone: _____
Alternate: _____ Work Day Other

E-MAIL ADDRESS: _____

We do NOT share this information with anyone. E-mail is a way for your doctor to communicate with you, to receive information about your procedure and to send reminders. How would you prefer for us to communicate with you? Phone (home cell alternate) E-Mail

RESPONSIBLE PARTY: _____

D.O.B (of responsible party) _____

Phone: _____ Relationship _____

EMPLOYER NAME & ADDRESS _____

Occupation: _____

EMERGENCY CONTACT: _____ Phone: _____

(Not in the same household)

INSURANCE INFORMATION

Primary Insurance: _____ Policy Holder: _____

Group# _____ Policy# _____ D.O.B. _____

Primary Address: _____ Insurance Phone: _____

Secondary Insurance: _____ Policy Holder: _____

Group# _____ Policy# _____ D.O.B. _____

Secondary Address: _____ Insurance Phone: _____

AUTHORIZATION AND RELEASE

Signature of patient or parent, if minor _____ Date _____ Signature of witness _____

PLEASE NOTE: Most medical insurance policies do not cover refraction services.

HOW WERE YOU REFERRED TO OUR OFFICE? (mark all that apply)

Doctor (Name: _____) Friend/Relative (Name: _____)

Newspaper Radio/Television Internet Yellow Pages Reputation Website

Insurance Social Media (ex. Facebook) Health Fair/Expo Drive By Previous Patient