PATIENT REGISTRATION FORM

PATIENT DEMOGRAPHICS

PATIENT NAME: ____

MAILING ADDRESS: ____

DATE OF BIRTH: ___________________________________

SOCIAL SECURITY: _________________________________

GENDER: ____

RACE: ____

ETHNICITY (Hispanic, Non-Hispanic or Decline): _____________________________________

EMAIL ADDRESS: ____

HOME PHONE: ___________________________________

CELL PHONE: ___________________________________

WORK PHONE: ___________________________________

MARITAL STATUS (Single, Married or Other): _______________________________________

EMPLOYMENT STATUS (Employed, Unemployed, Student, Retired, Homemaker): ____________

EMPLOYER: ____

REFERRING PHYSICIAN / OPTOMETRIST: ____

PRIMARY CARE PHYSICIAN: ____

EMERGENCY CONTACT

NAME: ____

PHONE: _______________________________________

RELATIONSHIP TO PATIENT: ____

(COMPLETE FRONT AND BACK OF THIS FORM)

PRIMARY INSURANCE

INSURANCE COMPANY: ____

MEMBER ID: ____

POLICY HOLDERS'S NAME: ____

POLICY HOLDER'S DATE OF BIRTH: _____________________

POLICY HOLDER'S RELATIONSHIP TO PATIENT: ____

SECONDARY INSURANCE

INSURANCE COMPANY: ____

MEMBER ID: ____

POLICY HOLDER'S NAME: ____

POLICY HOLDER'S DATE OF BIRTH: _____________________

POLICY HOLDER'S RELATIONSHIP TO PATIENT: ____

TERTIARY INSURANCE

INSURANCE COMPANY: ____

MEMBER ID: ____

POLICY HOLDER'S NAME: ____

POLICY HOLDER'S DATE OF BIRTH: _____________________

POLICY HOLDER'S RELATIONSHIP TO PATIENT: ____

GUARANTOR / LEGAL GARDIAN / POWER OF ATTORNEY

NAME: ____

MAILING ADDRESS: ____

DATE OF BIRTH: ____________________________________

PHONE: ____

RELATIONSHIP TO PATIENT: ____

____ ___________________________

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE