DR. SMITH'S EYE CARE

REGISTRATION

1. **PATIENT INFORMATION**

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Primary Phone: _____ **(please circle) home work cellphone**

Secondary Phone: _____ **(please circle) home work cellphone**

Email address: _____

Date of Birth: _____ **Age:** _____

SSN#: _____ **Sex: Male Female**

Race: _____ **(please circle) Hispanic/Latino Non-Hispanic/Latino**

Employer/School: _____ **Occupation/Grade:** _____

Marital Status (please circle one): Single Married Divorced Separated Widowed Minor Partnered for _____ years

2. **VISION INSURANCE**

Insurance Carrier: _____ **Policy/Group#:** _____

Person responsible for this account: _____

Primary card holder: _____

Primary's DOB: _____ **SSN#:** _____

Primary's relationship to patient: _____

3. **HEALTH INSURANCE**

Insurance Carrier: _____ **Policy/Group#:** _____

Person responsible for this account: _____

Primary card holder: _____

Primary's DOB: _____ **SSN#:** _____

Primary's relationship to patient: _____

4. **OTHER INFORMATION**

Communication preference (please circle): Phone Email Mail

IN CASE OF EMERGENCY, CONTACT

Name: _____ **Relationship:** _____

Primary Phone: _____ **(please circle) home work cellphone**

Name: _____ **Date:** _____

Signature: _____

Relationship to patient: _____