DR. SMITH'S EYE CARE

REGISTRATION FORM

Name: _____ **Sex**: □ M □ F **Date of Birth**:_____/_____/_____

Nickname: _____ **Patient Soc. Sec. #**: __ __ __ - __ __ - __ __ __ __

Street Address: _____

City: _____ **State**: _____ **Zip**: _____ □ I receive mail here

Mobile Phone: _____ **Secondary Phone**: _____

Email: _____

Preferred method of contact: □ Home Phone □Cell Phone □Email □Text □Postal Mail

Marital Status: □ Single □ Married □Divorced □Separated □Widowed □Minor □Other:___

Ethnicity: □Not Hispanic/Latino □Hispanic/Latino **Preferred Language:** □English □Spanish □Other _____

Race: □American Indian/Alaskan Native □Asian □Black/African American □Hawaiian/Other Pacific Islander □White □Other _____

Employment Status: □Employed FT □Employed PT □Not Employed □Retired □Student FT □Student PT
Employer/School: _____ **Occupation/Grade**: _____

Primary Medical Insurance

Carrier: □Medicare □Medicaid □Aetna □BC/BS □Cigna □Humana □Other_____

□ Louisiana Healthcare □Healthy Blue □Amerihealth Caritas □Aetna Better Health □United Healthcare Community

Member ID#: _____ Group #: _____

Name: _____ **Primary's DOB**: _____ **Primary's SSN#**: __ __ __ - __ __ - __ __ __ __

Vision Plan Information

Carrier: □Medicaid □Medicare □VSP □EyeMed □Davis □Always Care □Spectera Other _____

□ Louisiana Healthcare □Healthy Blue □Amerihealth Caritas □Aetna Better Health □United Healthcare Community

Member ID#: _____

Name: _____ **Primary's DOB**: _____ **Primary's SSN#**: __ __ __ - __ __ - __ __ __ __

Emergency Contact Name/Phone #: _____

□Ok to discuss medical information with this person

How Did You Choose Our Office? Referred by: _____

□Insurance List □Yellow Pages □Website □Facebook □Other _____

Name: _____ Date: _____

Signature: _____

Relationship to patient: _____