Date: ____________________

Dr. Smith's Eye Care
REGISTRATION

1. PATIENT INFORMATION

Name: ______________________________ Nickname (if any): ______________
Address: ____
City: ______________________________ State: __________ Zip: __________
Primary Phone: ______________________ *(please circle)* home work cellphone
Secondary Phone: ____________________ *(please circle)* home work cellphone
E-mail address: ____
Birthdate: ______________________________ 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

Person responsible for this account: ______________________________
Primary card holder: ______________________________
Primary's DOB: ______________________ SSN #: ______________
Primary's relationship to patient: ______________________________
Insurance Carrier: ______________________ Policy/Group #: ______________

3. HEALTH INSURANCE

Person responsible for this account: ______________________________
Primary card holder: ______________________________
Primary's DOB: ______________________ SSN #: ______________
Primary"s relationship to patient: ______________________________
Insurance Carrier: ______________________ Policy/Group #: ______________

4. OTHER INFORMATION

Whom may we thank for referring you to our office: ______________________
Communication preference *(please circle)*: Phone E-mail Mail
Persons allowed to receive personal information about patient: ______________
____

IN CASE OF EMERGENCY, CONTACT (specify someone who does not live in your household)
Name: ______________________ Relationship: ______________
Primary Phone: ______________________ *(please circle)* home work cellphone

Name: ______________________________ **Date:** ______________
Signature: ______________________________
Relationship to patient: ______________________________