

PATIENT REGISTRATION FORM

Today's Date \_\_\_\_\_ Optometrist Name: \_\_\_\_\_

PATIENT INFORMATION: (Please use the full legal name, no nicknames)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Social Security #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Drivers Lic#: \_\_\_\_\_

Employer Name and Address: \_\_\_\_\_

Work Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email Address: \_\_\_\_\_ Cell Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Emergency Contact Name/Relationship: \_\_\_\_\_

Emerg Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Referred by? Dr. \_\_\_\_\_ Friend \_\_\_\_\_ Phone Book \_\_\_\_\_ Bill Board \_\_\_\_\_ Web Site \_\_\_\_\_

GUARANTOR INFORMATION: If different from patient. (List person responsible for bill – use full legal name, no nicknames)

Relationship of Guarantor to Patient: Spouse \_\_\_\_\_ Parent \_\_\_\_\_ Other \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Social Security #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Female \_\_\_\_\_ Male \_\_\_\_\_

Employer Name and Address: \_\_\_\_\_

Work Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards) Only complete if Policyholder is different from patient

PRIMARY INSURANCE:

Plan Name: \_\_\_\_\_ Policyholder's Name: \_\_\_\_\_

Policyholder's Social Security #: \_\_\_\_\_ Policyholder's Date of Birth: \_\_\_\_\_

Policy / ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ Eff Date: \_\_\_\_\_

Claims Address & Phone: \_\_\_\_\_

SECONDARY INSURANCE:

Plan Name: \_\_\_\_\_ Policyholder's Name: \_\_\_\_\_

Policyholder's Social Security #: \_\_\_\_\_ Policyholder's Date of Birth: \_\_\_\_\_

Policy / ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ Eff Date: \_\_\_\_\_

Claims Address & Phone: \_\_\_\_\_