The Center for Eye Care and Optical

Patient Registration Form

Patient Information:

Patient Name:_____

Address: _____

Date of Birth: _____ Gender: □ Female □ Male

Home Phone: ( ) _____ Work Phone: ( ) _____

Cell Phone: ( ) _____ Email Address: _____

SSN: _____

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

Ethnicity: □ Hispanic or Latino □ Non Hispanic or Latino

Language (other than English): _____

Emergency Contact # ( ) _____ Relationship / Name: _____

Primary Care Physician: _____ Endocrinologist (if any): _____

How were you referred to our office? _____

Responsible Party Information:
Note –The financially responsible party can never be a child. If the patient is a minor, fill in responsible parent or guardian.

Is the responsible party the same as the patient: □ Yes □ No *(if no, please fill in the information below)*

Name:_____

Address: _____

Date of Birth: _____ Gender: □ Female □ Male

Home Phone: ( ) _____ Work Phone: ( ) _____

Cell Phone: ( ) _____ Email Address: _____

SSN: _____ Relationship: _____

The Center for Eye Care and Optical

Medical Insurance Information:

Primary

Primary Insurance Plan Name	
Primary Insurance Address	
Primary Insurance Phone #	
Insured Name:	Relationship to Patient:
Insured Address:	
Insured Date of Birth	Gender: □ Female □ Male
Member ID #	

Secondary

Secondary Insurance Plan Name	
Secondary Insurance Address	
Secondary Insurance Phone #	
Insured Name:	Relationship to Patient:
Insured Address:	
Insured Date of Birth	Gender: □ Female □ Male
Member ID #	

Vision Plan

Vision Plan Insurance Plan Name □ Davis □ EyeMed □ Spectera □ VSP	
Vision Plan Insurance Address	
Vision Plan Insurance Phone #	
Insured Name:	Relationship to Patient:
Insured Address:	
Insured Date of Birth	Gender: □ Female □ Male
Member ID #	

Is Your Condition Related to: □ Employment □Auto Accident

I acknowledge that the above information is correct and I accept financial responsibility for any services rendered for my dependent or myself.

Signature:_____ **Date:**_____

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