REGISTRATION INFORMATION: PLEASE FILL OUT

Welcome to our office. We are committed to providing you with the finest, most comprehensive care possible. All information is confidential and is only released with your written consent.

Today's Date _____

Name _____ Preferred (Nickname) _____

Birth Date _____ Age _____ Sex _____ Social Security Number _____

Marital Status _____ Name of Spouse _____

Address: _____
Street City State Zip Code

Mailing Address: _____
Street / PO Box City State Zip Code

Home Phone: (____) _____ **Cell Phone (Important):** (____) _____

Business Phone: (____) _____ Occupation / Employer: _____

Email Address: _____

Consulting Ophthalmologist (Eye MD) _____

Consulting Optometrist (OD) _____

Primary Care Physician _____ Phone: (____) _____

Address _____
Street / PO Box City State Zip Code

Pharmacy _____ City / Location _____ Phone _____

Preferred Language (Please circle one): English Spanish French German Italian Mandarin Vietnamese Other: _____

Race (Please circle one): Caucasian Hispanic/Latino Asian Native American or Alaskan Native African American Japanese Native Hawaiian or Other Pacific Islander Undetermined Other: _____

Primary Insurance _____

Subscriber (if different than patient) _____ Date of Birth: _____

Secondary Insurance _____

Subscriber (if different than patient) _____ Date of Birth: _____

Tertiary Insurance _____

Subscriber (if different than patient) _____ Date of Birth: _____

Are you currently residing in a Skilled Nursing Facility ? Yes_____ No_____

Are you currently enrolled in a Hospice program ? Yes_____ No_____

Is your visit related to a **work injury**? Yes_____ No_____ Date of Injury: _____

Is your visit related to an **auto accident**? Yes_____ No_____ Date of Accident: _____

OVER

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Responsible Party Information For Minors

Patient Name: _____ DOB: _____ Today's Date: _____

Responsible Party (Primary) _____

SSN _____ Relationship to Patient _____ Date of Birth _____ Sex ____

Address _____

Street / PO Box City State Zip Code

Home Phone: (____) _____ Other Phone: (____) _____

Employer _____ Occupation _____

Responsible Party (Secondary) _____

SSN _____ Relationship to Patient _____ Date of Birth _____ Sex ____

Address _____

Street / PO Box City State Zip Code

Home Phone: (____) _____ Other Phone: (____) _____

Employer _____ Occupation _____

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