

PATIENT REGISTRATION

PATIENT NAME (LAST - FIRST - MIDDLE)		DATE OF BIRTH	AGE	MARITAL STATUS
				S M OTHER
ADDRESS (STREET - CITY - ZIP)			HOME PHONE	
			()	
EMPLOYER	WORK PHONE	OCCUPATION		SOC. SECURITY NO.
	()			
SPOUSE'S OR GUARDIAN'S NAME	DATE OF BIRTH	EMPLOYER		WORK PHONE
				()
ADDRESS (STREET - CITY - ZIP)	HOME PHONE	WHO MAY WE THANK FOR REFERRING YOU?		
	()			
IN CASE OF EMERGENCY NOTIFY:		RELATIONSHIP TO YOU		DAY PHONE
				()
FAMILY PHYSICIAN(S)	PHONE	MEDICAL ALERTS		
	()			
WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL?		METHOD OF PAYMENT (circle one)		
		CASH CHECK CREDIT CARD INSURANCE		

INSURANCE INFORMATION

PRIMARY INSURANCE	ADDRESS (STREET - CITY - STATE - ZIP)		PHONE
			()
NAME OF INSURED	RELATIONSHIP	ID NUMBER	GROUP NUMBER
SECONDARY INSURANCE	ADDRESS (STREET - CITY - STATE - ZIP)		PHONE
			()
NAME OF INSURED	RELATIONSHIP	ID NUMBER	GROUP NUMBER
ROUTINE VISION COVERAGE	RELATIONSHIP	ID NUMBER	GROUP NUMBER

SIGNATURE ON FILE

YES NO

X	
X	
X	
X	
X	
X	

- I AUTHORIZE USE OF THIS FORM ON ALL MY INSURANCE SUBMISSIONS
- I AUTHORIZE RELEASE OF INFORMATION TO ALL MY INSURANCE CARRIERS
- I UNDERSTAND I AM RESPONSIBLE FOR MY BILL & COLLECTION COSTS
- I AUTHORIZE MY DOCTOR TO ACT AS MY AGENT IN HELPING ME TO OBTAIN PAYMENT
- I AUTHORIZE PAYMENT DIRECTLY TO MY DOCTOR
- I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL

SIGNATURE: _____ **DATE:** _____