

# Patient Registration Form



## PATIENT INFORMATION:

Last Name:		First Name:		MI:	Birth Date:	
Address:			City:		State:	Zip:
Home Phone:			Cell Phone:			
Email Address:			Age:	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security #	
Occupation:		Employer:		Employer Phone:		
Employer Address:			City:		State:	Zip:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			Spouse's Name:			
Spouse's Birth Date:		Spouse's Social Security #:		Spouse's Employer:		Phone Number:

## PLEASE COMPLETE IF PATIENT IS UNDER AGE 18 OR A COLLEGE STUDENT:

Father's Last Name:		Father's First Name:		MI:	Father's Birth Date:	
Father's Employer:			Father's Employer Phone:			
Father's Address:			City:		State:	Zip:
Father's Home Phone:		Father's Cell Phone:		Fathers' Social Security #:		
Mother's Last Name:		Mother's First Name:		MI:	Mother's Birth Date:	
Mother's Employer:			Mother's Employer Phone:			
Mother's Address:			City:		State:	Zip:
Mother's Home Phone:		Mother's Cell Phone:		Mother's Social Security #:		

## REFERRAL INFORMATION:

Name of Family Physician:		Name of Optometrist:	
Were you referred here today by any of your physicians? If so, whom?:			

(Please complete back side)

### MEDICARE PATIENTS WHO HAVE PART B:

Medicare Number:	Effective Date:
1. Do you or your spouse work for a company that provides you with health insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are you entitled to Medicare because of disability or End-Stage Renal Disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is the illness or injury the result of an automobile accident or other injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has the treatment for the accident or illness been authorized by the Veteran's Admin?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Are you entitled to any benefits under the Federal Black Lung Program?	<input type="checkbox"/> Yes <input type="checkbox"/> No

### PRIMARY INSURANCE

Name of Insurance:	ID Number:
Employer:	Group Number:
Who is the subscriber:	Do you need a referral?: <input type="checkbox"/> Yes <input type="checkbox"/> No
Subscriber's Date of Birth:	Subscriber's Social Security #:

### SECONDARY INSURANCE

Name of Insurance:	ID Number:
Employer:	Group Number:
Who is the subscriber:	Do you need a referral?: <input type="checkbox"/> Yes <input type="checkbox"/> No
Subscriber's Date of Birth:	Subscriber's Social Security #:

### WORKMAN'S COMP. OR AUTO INSURANCE:

Where should bill be sent?:	Phone Number:		
Address:	City:	State:	Zip:
Claim or Policy Number:	Date of Injury:		

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_