



## REGISTRATION INFORMATION: PLEASE FILL OUT

*Welcome to our office. We are committed to providing you with the finest, most comprehensive care possible. We encourage you to ask questions, to let us know your concerns, and to communicate openly with us. Please assist us by providing the following information. All information is confidential and is only released with your written consent.*

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ Preferred (Nickname) \_\_\_\_\_

Marital Status \_\_\_\_\_ Name of Spouse \_\_\_\_\_

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

Street / PO Box

City

State

Zip Code

Alternate (Mailing) Address: (if different from above)

Street / PO Box

City

State

Zip Code

Home Phone: (\_\_\_\_) \_\_\_\_\_ **Cell Phone (Important):** (\_\_\_\_) \_\_\_\_\_

Business Phone: (\_\_\_\_) \_\_\_\_\_ Occupation / Employer: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_ Social Security Number \_\_\_\_\_

Are you currently residing in a Skilled Nursing Facility? Yes \_\_\_\_ No \_\_\_\_

Are you currently enrolled in a Hospice program? Yes \_\_\_\_ No \_\_\_\_

Consulting Ophthalmologist (Eye MD) \_\_\_\_\_

Consulting Optometrist (OD) \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

Street / PO Box

City

State

Zip Code

**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: \_\_\_\_\_

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: \_\_\_\_\_

Pharmacy \_\_\_\_\_ City / Location \_\_\_\_\_ Phone \_\_\_\_\_

**OVER**

## RESPONSIBLE PARTY INFORMATION

**Responsible Party** \_\_\_\_\_

SSN \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_  
Street / PO Box City State Zip Code

Home Phone: ( ) \_\_\_\_\_ Other Phone: ( ) \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_