# PATIENT REGISTRATION FORM

**Please PRINT. All information must be completed. If not applicable, please mark N/A.**

**Name: Last, First, MI** _____ **Today's Date:** _____

**If minor, Responsible Parent Name:** _____ **Date of Birth:** _____

**Marital Status: Married/Divorced/Single/Widowed/Separated** **SSN#:** _____

**Home Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

**Other Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

**Home Phone:** _____ **Cell Phone:** _____ **Work Phone:** _____

***Do You..... Prefer we call your home or cell number? HOME / CELL Wish to receive TEXT reminders for upcoming appts? YES / NO***

**Email address:** _____

***Would you like to receive EMAIL reminders about upcoming appts? YES / NO***

**Employer:** _____ **Occupation:** _____

**Primary Care Physician Name:** _____ **PCP Phone #:** _____

**Referring Physician Name (if different from above):** _____ **Ref Phys #:** _____

**Emergency Contact:** _____ **Relationship:** _____ **Phone #:** _____

## MEDICAL INSURANCE INFORMATION

**Primary Insurance:** _____ **Member ID#:** _____

**Insured Party's Name:** _____ **Insured's DOB:** _____

**Relationship to Insured: Self / Spouse / Child / Other** _____ **Insured's SSN#:** _____

**Secondary Insurance:** _____ **Member ID#:** _____

**Insured Party's Name:** _____ **Insured's DOB:** _____

**Relationship to Insured: Self / Spouse / Child / Other** _____ **Insured's SSN#:** _____

## ROUTINE/VISION INSURANCE INFORMATION

**Vision Insurance:** _____ **Member ID#:** _____

**Insured Party's Name:** _____ **Insured's DOB:** _____

**Relationship to Insured: Self / Spouse / Child / Other** _____ **Last 4 of SSN#:** _____

****** PLEASE TAKE NOTE! Medical Examinations and Treatment are not covered by ROUTINE Vision Plan Insurance. ******

## THIRD PARTY LIABILITY INFORMATION

**Is your visit work or accident related? Yes / No If Yes, Type of Accident: Auto / Work Related Injury / Other:** _____

**Responsible Party Name:** _____ **Resp Party Phone #:** _____

**Name of attorney representing patient related to this service:** _____ **Attorney Phone #:**_____

**I acknowledge that the information provided is complete and accurate.**

_____

**Patient/Designated Representative Print Name**

_____ _____

**Patient/Designated Representative Signature** **Date**