

Patient Registration

Patient Name: _____ Date of Birth: ____ / ____ / ____

Social Security Number: _____ ☐ Declined Sex: ☐ Male ☐ Female

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Number: _____ Cell Number: _____

Work Number: _____ Email: _____

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Other

Race: ☐ African American/ Black ☐ American Indian/Alaska Indian ☐ Asian ☐ Caucasian/ White
☐ Native Hawaiian/Pacific Islander ☐ Unspecified

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unspecified ☐ Declined

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Emergency Contact: _____ Relationship: _____

Address: _____ Phone Number: _____ DOB: ____ / ____ / ____

Please indicate which doctor you were referred to see: _____

Optometrist (Eye Doctor): _____ Phone Number: _____

Primary Care Physician (PCP): _____ Phone Number: _____

Preferred Pharmacy: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Patient Employment: ☐ Employed ☐ Retired ☐ Student ☐ Other: _____

Occupation: _____ Employer: _____ Phone Number: _____

Patient Insurance Information

Please provide the front desk with your current insurance card(s).

Is the insurance in your name? ☐ Yes (Skip SECTION B) ☐ No (Fill out SECTION B below)

SECTION B: Guarantor's Information (person responsible for today's fee's) ☐ Spouse ☐ Guardian ☐ Other

Guarantor Name: _____ Date of Birth: ____ / ____ / ____

Date of Birth: ____ / ____ / ____ Social Security Number: _____ Driver's Lic. Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Number: _____ Cell Number: _____

Guarantor's Employer: _____ Employer Number: _____