PATIENT REGISTRATION FORM

Patient Information

PATIENT NAME (LAST)			FIRST		M.I.
STREET ADDRESS			CITY	STATE	ZIP CODE
HOME PHONE #	SEX	DATE OF BIRTH	SOCIAL SECURITY #	AGE	MARITAL STATUS S M D W
SPOUSE'S NAME			SPOUSE'S BIRTHDATE		
PATIENT'S EMPLOYER / OCCUPATION			WORK PHONE #		EXT. #
IN CASE OF AN EMERGENCY CONTACT *(OTHER THAN SPOUSE)*			RELATIONSHIP	PHONE #	
PRIMARY CARE PHYSICIAN OR MEDICAL DOCTOR			NAME OF OPTOMETRIST		
ADDRESS AND PHONE # OF PHYSICIAN					

REFERRED BY

IF PATIENT IS A CHILD:

NAME OF SCHOOL _____ GRADE _____

SCHOOL DISTRICT _____

AUTHORIZATION TO SEND FOLLOW UP REPORT TO THE SCHOOL NURSE _____
SIGNATURE

Responsible Party Information *(Complete ONLY if different from above information.)*

PATIENT NAME (LAST)			FIRST		M.I.
STREET ADDRESS			CITY	STATE	ZIP CODE
HOME PHONE #	RELATIONSHIP		BIRTHDATE	SOCIAL SECURITY #	
EMPLOYER			WORK PHONE #		

Insurance Information *(Please bring insurance cards to appointment.)*

PRIMARY INSURANCE			POLICY #	GROUP #
POLICY HOLDER	POLICY HOLDER'S BIRTHDATE	RELATIONSHIP	SOCIAL SECURITY #	
SECONDARY INSURANCE			POLICY #	GROUP #
POLICY HOLDER	POLICY HOLDER'S BIRTHDATE	RELATIONSHIP	SOCIAL SECURITY #	
OTHER INSURANCE				

WORKER'S COMPENSATION: **VERIFIED** _____ ❑ **YES** ❑ **NO** **EMPLOYER** _____

INSURANCE COMPANY NAME & ADDRESS _____

_____ **EMPLOYER PHONE** _____