complete family
EYECARE

PATIENT REGISTRATION

Date_____

What is your preferred method of payment: Credit/Debit _____ Check _____ Cash _____

Last Name:_____ First Name:_____

Middle Initial:_____ Preferred Name:_____ Sex: M_____ F_____

Address_____ City_____

State:_____ Zip Code:_____

Birth Date: _____ Age: ____ Social Security#: _____

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

Emergency Contact: _____ PH#:_____

E-mail Address:_____

Marital Status: Single ____ Married ____ Divorced____ Other_____

Employer/ School:_____ Occupation/Grade:_____

Employer Address:_____

Family Doctor:_____ **Preferred Pharmacy**:_____

Names of Family Members in Household_____

_____

Responsible Party:_____

INSURANCE INFORMATION:

Private Pay:_____ Primary Insurance:_____ ID #_____

Secondary Insurance:_____ ID # _____

*We must have a copy of all insurance cards on the day of service Insured's

Name:_____ Insured's DOB:_____ Insured's Social Security #:_____

Policy Holder's place of Employment_____