Patient Registration

Please verify the following information, make necessary changes and supply any missing information.

Patient Information

				Date of Birth	Today's Date
Patient Name (First, Middle, Last)	Suffix (Jr.,Sr.)	Salutation (Mr.,Ms.)	Preferred Name	Sex	Age
Address (Street, City, State, Zip)					
Home Phone	Cell Phone	Email Address			
Primary Language	Special Needs (Wheelchair, Translator Hearing Impaired)	Social Security #	Primary Eye Doctor		
Primary Care Physician	Primary Care Physician Phone	Other Specialist Eye Doctors	Other Specialist Phone		

Parent/Legal Guardian (If patient is under 18)/Account Responsible:

		Patient's Relationship to the Responsible Party (Self, Spouse, Child)		
Responsible Party's Name (Salutation, First, Middle, Last)	Date of Birth	Home Phone	Cell Phone	Work Phone / Ext
Address (Street, City, State, ZIP)		Email Address	Social Security #	Gender

Primary Insurance

Insured's Name	Insurance Company Name

Secondary Insurance

Insured's Name	Insurance Company Name

Contacts

Name / Relationship	Emergency Contact	Release of Medical Information	Phone

Signature: _____ **Date:** _____