

Welcome!

REGISTRATION FORM

Section I: Patient Information

Date _____

Name: _____ I Prefer to be called:

Address: _____
City: _____ State: _____ Zip _____

Phone (____) _____ Work Phone (____) _____ Cell Phone
(____) _____

Date of Birth: _____ Social Security Number: _____

Check Appropriate Box: Minor Single Married Widowed Separated Divorced

Spouse or Parent's Name: _____ Employer _____ Work
Phone _____

Whom may we thank for referring you?

Person to contact in case of emergency _____
Phone _____

Email Address _____ Do you receive text messages?

Section II Responsible Party

Relationship to Patient: Self Spouse Parent Other

Name: _____ Relationship to Patient:

Welcome!

Address: _____

City: _____ State: _____ Zip: _____ Phone:
(____) _____

Employer _____ Work Phone (____) _____
SSN# _____

Section III

Major Medical Insurance Information

Name of Insured _____ DOB _____ Relationship to Patient

SSN#: _____ Name of Employer: _____ Work Phone: (____)

Address of Employer: _____ City _____ State: _____ Zip

Insurance Company _____ Grp # _____
ID# _____

Ins Co Address: _____ Ins Co.
Phone: _____

Vision Insurance

----- DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE
FOLLOWING -----

Name of Insured _____ DOB _____ Relationship to Patient

SSN#: _____ Name of Employer: _____ Work Phone: (____)

Address of Employer: _____ City _____ State: _____ Zip

Insurance Company _____ Grp # _____
ID# _____

Ins Co Address: _____ Ins Co.
Phone: _____

Welcome!

PLEASE SHOW YOUR INSURANCE CARD AND DRIVERS LICENSE