PATIENT REGISTRATION FORM

WELCOME TO OUR OFFICE!

Last Name First Middle Age Date of Birth

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Message/Cell Phone: _____ Social Security #: _____

Employer: _____ Driver's License #: _____

Occupation: _____

Spouse's Name: _____ Spouse's Work Phone: _____

PERSON LEGALLY RESPONSIBLE

(Guarantor of insurance/person who the insurance is under)

Last Name First Middle Age Date of Birth

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Message/Cell Phone: _____ Social Security #: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

Insurance is a wonderful protection to have, but please understand that you are responsible for this account and that any account past ninety days is considered delinquent. Please be advised we do not routinely bill the second and third insurances. If you have any questions or concerns about your account, please call our office for assistance.

The undersigned patient, or individual acting on behalf of the patient, agrees as follows:

1. Authority is granted to Family Eye Care to render needed treatment to the above named patient.
2. Permission is granted to Family Eye Care to release information regarding medical treatment rendered to the insurance company or referring physician.
3. I authorize payment of medical benefits to Family Eye Care for services provided to the patient described above.

Date: _____ Signature: _____

Parent or Guardian Signature: _____