Patient Registration

Dr. Miss
Mr. Ms.
Mrs. _____

Circle One | First Name | Middle | Last name | Date of Birth | Social Security #

_____

Address | City | State | Zip

_____

Home Phone | Cell Phone | Work Phone | Email

_____

Employer Name/Address | Spouse

Race
- ☐ American Indian or Alaskan American
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Black
- ☐ Caucasian/White
- ☐ No Answer Given

Ethnicity
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ No Answer Given

Preferred Contact Method
- ☐ Home Phone
- ☐ Cell Phone
- ☐ Email
- ☐ Text

How did you hear about us?
- ☐ Already a Patient
- ☐ Phone Book
- ☐ Dr. Referral
- ☐ Insurance Listing
- ☐ Website
- ☐ Facebook
- ☐ Friend _____
- ☐ Family _____

Gender
- ☐ Male
- ☐ Female

Preferred Language
- ☐ English
- ☐ Other (please specify)_____

Insurance Information

_____

Vision Insurance Name | Policy Number | Group Number

_____

Insured's Name | Insured's Date of Birth | Insured's Social Security # | Relationship to Patient

Responsible Party (if different than patient)

Name _____

Date of Birth _____

Soc Sec # _____

Address _____

City/State/Zip _____

Home Phone _____

Cell _____

Employer Name _____

Work Phone _____

Additional Information

Primary Physician_____

City _____

May we communicate/correspond with your primary physician regarding your care? Circle one Yes No Please initial_____

Pharmacy/City _____

I authorize doctors and staff to disclose information regarding my medical treatment and diagnosis and information regarding my financial account with the following individuals:

_____
Name/Relationship

_____
Name/Relationship

_____
Name/Relationship

See Reverse