Patient Registration Form

Please use Black Ink only to fill out forms.

☐ ***Please check this box if you are a winter visitor. If so, please provide both addresses.***

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

LEGAL Name: _____

Last *First* *MI*

Marital Status: _____

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

Local Address: _____

Street *Apt#* *City* *State* ***9 DIGIT ZIP***

Mailing Address: _____

Street *Apt#* *City* *State* ***9 DIGIT ZIP***

RACE: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown ☐ Other _____ ☐ Refuse

PRIMARY LANGUAGE: ☐ English ☐ Spanish ☐ Other _____ ☐ Refuse

ETHNICITY: ☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino ☐ Unknown ☐ Refuse

MEDICAL INFORMATION: Who is your Medical Doctor? _____

Address: _____ Phone _____

Your Home Phone: _____ Cell Phone: _____

Alternate: _____ ☐*Work* ☐*Day* ☐*Other*

E-MAIL ADDRESS: _____

We do NOT share this information with anyone. E-mail is a way for your doctor to communicate with you, to receive information about your procedure and to send reminders. How would you prefer for us to communicate with you? ☐*Phone (*☐*home* ☐*cell* ☐*alternate)* ☐*E-Mail*

RESPONSIBLE PARTY: _____

D.O.B *(of responsible party)* _____

Phone: _____ Relationship _____

EMPLOYER NAME & ADDRESS _____

_____

Occupation: _____

EMERGENCY CONTACT: _____ Phone: _____

(Not in the same household)

INSURANCE INFORMATION

Primary Insurance: _____ Policy Holder: _____

Group# _____ Policy# _____ D.O.B. _____

Primary Address: _____ Insurance Phone: _____

Secondary Insurance: _____ Policy Holder: _____

Group# _____ Policy# _____ D.O.B. _____

Secondary Address: _____ Insurance Phone:

☐ I give consent for treatment at Barnet Dulaney Perkins Eye Center facility

AUTHORIZATION AND RELEASE

_____ _____ _____

Signature of patient or parent, if minor *Date* *Signature of witness*

PLEASE NOTE: Most medical insurance policies do not cover refraction services.

HOW WERE YOU REFERRED TO OUR OFFICE? ***(mark all that apply)***

☐Doctor (Name: _____) ☐ Friend/Relative (Name: _____)

☐Newspaper ☐ Radio/Television ☐Internet ☐ Yellow Pages ☐ Reputation ☐Website

☐Insurance ☐Social Media (ex. Facebook) ☐ Health Fair/Expo ☐Drive By ☐Previous Patient