

PATIENT REGISTRATION FORM

Thank you for choosing our office for your eye care! Please help us by completing this form accurately.

_____/_____/_____/_____/_____/_____
Title First Name Middle Name Last Name Suffix Preferred Name/ Nickname

_____/_____/_____/_____/_____/_____
Residence Address (Number, Street, Apartment) City State Zip Code

_____/_____/_____/_____/_____/_____
Mailing Address (Only if Different from Above) City State Zip Code

The best telephone numbers to contact you during our normal business hours (9-5 M-F)?
Email (optional): _____
Gender: Male Female
 Cell (_____) _____/
 Work (_____) _____/
 Home (_____) _____/
 Pager (_____) _____/

Marital Status: Single Married Other Date of Birth : ____ - ____ - ____ / SSN: ____ - ____ - ____ /
(MM-DD-CCYY)

Employed? Yes No _____/
Employer's Name Occupation/Job Title

Full-time Student? Yes No, Part-time Student? Yes No _____/
Name of School Grade Level

In Case of Emergency, Contact: _____ at (_____) _____/
Emergency Contact Name (First, Middle, Last, Suffix) Emergency Contact Phone Number

INSURANCE INFORMATION

_____/_____/_____/_____/_____/_____
HEALTH INSURANCE (BC of CA, etc.) Full Name of Insured (First, Middle, Last, Suffix) Insured's ID Number
Insured's Relationship to Patient: Self Spouse Domestic Partner Father Mother Guardian Child Other _____/

_____/_____/_____/_____/_____/_____
VISION INSURANCE (VSP®, etc.) Full Name of Insured (First, Middle, Last, Suffix) Insured's ID Number
Insured's Relationship to Patient: Self Spouse Domestic Partner Father Mother Guardian Child Other _____/

REFERRAL SOURCE

_____/_____/_____/_____/_____/_____
Name of Person to Thank for Referring You to Our Office (First, Middle, Last, Suffix) Family Member Co-Worker
 Friend Professional

If another person did not refer you, how were you referred to our office? VSP® Panel List/ Website BC of CA Panel List Mailer
 Convenient location YellowPages.com Office Website Other

ACKNOWLEDGEMENT OF OFFICE POLICIES

I certify that my responses on this form are accurate to the best of my knowledge. I certify that I understand cancellations on eyeglasses are not permitted as all eyeglasses are custom crafted for each patient with their unique prescription. I certify that I understand that there are no refunds or exchanges and that all sales are final. I also agree to refrain from cell phone use in the office. I assume all financial responsibility for this patient's account for any amounts due, regardless of Insurance Coverage.

⇒ _____/_____/_____/_____/_____/_____
Signature of Responsible Party Full Name of Responsible Party (First, Middle, Last, Suffix) _____ -2008
DATE SIGNED

Responsible Party's Relationship to Patient: Self Spouse Domestic Partner Father Mother Guardian Child Other _____/

****If Responsible Party is NOT the Patient:** (_____) _____/**Responsible Party's Contact Number
_____/_____/_____/_____/_____/_____
**Responsible Party's Address (Number, Street, Apt.) City State Zip Code