PATIENT REGISTRATION FORM

Thank you for choosing City Center Optometry 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)?

Cell (_______)________________________/
Work (_______)________________________/
Home (_______)________________________/
Pager (_______)________________________/

Email (optional): ____

Gender: Male Female

Marital Status: Single Married Other

Date of Birth : ______-______-_________/
(MM-DD-CCYY)

SSN:________-______-__________/

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.

⇒_______________________________________/ ____/ ______-______-2010
Signature of Responsible Party Full Name of Responsible Party (First, Middle, Last, Suffix) **DATE SIGNED**

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

<u>If Responsible Party is NOT the Patient:</u> (_______)______________________________/Responsible Party's Contact Number

____/ _______________________________/ ___/ _______/
**Responsible Party's Address (Number, Street, Apt.) City State Zip Code