PATIENT REGISTRATION FORM

Thank you for choosing City Center Optometry for your eye care needs! 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 (_____) _____/
Email (optional): _____ ☐ Home (_____) _____/
Gender: ☐Male ☐Female ☐ 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

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

⇒_____/ _____/ ____-____-2012
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_____/

****If Responsible Party is NOT the Patient:** (_____) _____/**Responsible Party's Contact Number

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