

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 Residence Address) City State Zip Code

Preferred method of communication: Phone, US Mail, Okay to text Cell, Okay to Email: _____/

The best telephone numbers to contact you during our normal business hours (9-5 M-F)?

Gender: Male, Female Cell (_____) _____/

Marital Status: Single, Married, Other Work (_____) _____/

Date of Birth: ____/____/____ Home (_____) _____/

Last 4 digits of SSN: XXX - XX - _____ Pager (_____) _____/

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

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

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

INSURANCE INFORMATION

_____/_____/_____/_____/_____/_____
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 _____/

_____/_____/_____/_____/_____/_____
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 _____/

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 that a cancellation fee of \$48 will be charged if I fail to appear, or if I cancel or reschedule within 24 hours of any scheduled appointment. 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) _____ -2019
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 Address (Number, Street, Apt.) City State Zip Code
**Responsible Party's Contact Number _____/