Eye Care & Vision Associates
PATIENT REGISTRATION

Welcome to our office. Please **print** all information in the spaces provided and return to the receptionist who will use this information to prepare your record.

Today's Date _____ Please Select → ☐ Miss ☐ Mrs. ☐ Ms ☐ Mr. ☐ Mstr ☐ Dr.

Patient _____
Last Name First Name Middle

Home Address _____
Street Apt/Box City State ZIP

Home Phone _____ Work Phone _____

Cell Phone _____ Email Address _____

Date of Birth _____ Social Security # _____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Other

Race _____ Language _____ Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic

Employer _____ Occupation _____

Employer Address _____
Street City State ZIP

Insurance Information

Primary Insurance _____ ID # _____ Group # _____

Secondary Insurance _____ ID # _____ Group # _____

Insurance Subscriber (if different from patient)

Name of Insured _____ Relation to Patient _____

Insured's Address (if different) _____
Street City State ZIP

Insured's Date of Birth _____ Insured's Social Security # _____

Guarantor (person responsible for payment) _____

Emergency Contact Name _____ Relationship to Patient _____

Emergency Contact Phone Number (other than home phone) _____

Parent/Guardian Name(s) (if patient is under 18) _____

Physician Information

Referring Physician _____ Primary Care Physician _____

Optometrist Name (if applicable) _____

How did you hear about our office? (Check One)

☐ Insurance Provider List ☐ MD Referral ☐ Optometrist Referral ☐ Hospital ☐ Nursing Home/Senior Ctr
☐ Patient (list name) _____ ☐ Friend/Family ☐ Church Bulletin ☐ Internet
☐ Newspaper ☐ Phone Book ☐ Radio ☐ TV ☐ Auction/Donation Ad ☐ Outdoor Sign ☐ Optical Shop