Patient Registration

APPT DATE_____ TIME_____ DOCTOR_____

NAME_____ SOCIAL SEC #_____

D.O.B____/___/____ AGE_____ Male/Female SINGLE___ MARRIED___ WIDOWED___ DIVORCED___

MAILING ADDRESS_____

CITY_____ STATE_____ ZIP_____

Home # ( ) _____ Work #_____ CELL # ( )_____

EMAIL_____

PLACE OF EMPLOYMENT_____ OCCUPATION_____

RETIRED (circle one) YES NO

NAME OF NURSING HOME IF APPLICABLE_____

PHONE # ( ) _____

GOVERNMENT RELATED QUESTIONS:

RACE: (circle one) WHITE HISPANIC AMERICAN INDIAN/ALASKAN NATIVE ASIAN

BLACK or AFRICAN AMERICAN HAWAIIAN or other PACIFIC ISLANDER DECLINE TO SPECIFY

ETHNICITY: (circle one) HISPANIC or LATINO NOT HISPANIC or LATINO UNKNOWN
DECLINE TO SPECIFY

RELIGION_____ **PRIMARY LANGUAGE**_____
DECLINE TO SPECIFY

SPOUSE INFORMATION:

NAME_____ SOCIAL SEC #_____

D.O.B____/____/____ PLACE OF EMPLOYMENT_____

CELL # ( ) _____ WORK # ( ) _____

OPTOMETRIST:

NAME OF OPTOMETRIST_____ PHONE # ( ) _____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

PRIMARY CARE PHYSICIAN_____

PHARMACY_____ **CITY**_____

(OVER)

PARENT'S INFORMATION:

IF PATIENT IS A CHILD, WHO IS FINANCIALLY RESPONSIBLE? _____

FATHER'S NAME_____ MOTHER'S NAME_____

EMPLOYER_____ EMPLOYER_____

HOME ADDRESS_____ HOME ADDRESS_____

DAY PHONE # ( ) _____ DAY PHONE # ( ) _____

CELL # ( ) _____ CELL # ( ) _____

SOCIAL SEC #_____ SOCIAL SEC #_____

D.O.B ___/____/____ D.O.B ____/____/____

INSURANCE INFORMATION:

*****PLEASE PRINT NAME AS IT APPEARS ON YOUR PRIMARY INSURANCE CARD*****

NAME OF POLICY HOLDER_____ D.O.B ____/____/____

MEDICARE NUMBER_____ MEDICAID NUMBER_____

OTHER MEDICAL INSURANCE_____

IDENTIFICATION #_____ GROUP #_____

WORKMAN'S COMPENSATION:

DID ACCIDENT HAPPEN AT WORK? (Circle one) **YES** **NO**

IF YES: NAME OF EMPLOYER_____ DEPT_____

EMPLOYER'S ADDRESS_____ PHONE # ( ) _____

CITY_____ STATE_____ ZIP_____

CONTACE PERSON_____

EMERGENCY CONTACT:

*****NAME OF FRIEND OR RELATIVE THAT DOES NOT LIVE WITH YOU THAT WE MAY CONTACT IN CASE OF AN EMERGENCY*****

NAME_____ RELATIONSHIP TO YOU_____

HOME PHONE # ( ) _____ CELL # ( ) _____

HOW DID YOU HEAR ABOUT US?

☐ Referring Provider ☐ Facebook / Web Search

☐ Family / Friend /Word-of-Mouth ☐ Newspaper / Flyer

☐ Radio Advertisement ☐ Other: _____