PATIENT REGISTRATION

Appointment Date:_____ Time: _____ Doctor: _____

We have reserved this time and date for your appointment. If you are unable to make this appointment, please call (620)275-7248 as soon as possible to reschedule. If you arrive more than 15 minutes late for your appointment, you may be asked to reschedule.

Name: _____ Social Sec #: _____

D.O.B:_____ Age:____ M:____ F:____Single____ Married____ Widowed____ Divorced____

Mailing address: _____

City: _____ State:_____ Zip:_____

Home #:_____ Work #:_____ Cell #: _____

Email address*: _____

Employer:_____

Name of nursing home (if applicable):_____

Nursing home phone #: _____

GOVERNMENT RELATED QUESTIONS

Race: White____ Hispanic____ American Indian/Alaska Native____ Asian____
Black/African American____ Hawaiian or other Pacific Islander____ Decline to specify____

Ethnicity: Hispanic/Latino____ Not Hispanic/Latino ____ Unknown____ Decline to specify ____

Preferred Language: _____

SPOUSE INFORMATION

Name:_____ Social Sec #:_____

D.O.B:_____ Best contact #: (___) _____

OPTOMETRIST

Name of optometrist:_____ Phone #: (___)_____

**By providing your email address you agree to receive communications from Fry Eye Associates and/or Fry Eye Surgery Center related to appointments, services, announcements and/or promotional offers. Collected information will not be shared with any third party and complies with our stated Privacy Policy.*

502 College Street
Garden City, Kansas 67846

Phone: 620-275-7248
Website: www.fryeye.com
fryeyeassociates

PATIENT REGISTRATION

PATIENT INFORMATION:

If patient is a child, who is financially responsible? _____

Father's name: _____ Mother's name: _____

Home address: _____ Home Address: _____

Cell #: (_____) _____ Cell #: (_____) _____

Work #: (_____) _____ Work #: (_____) _____

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? ___Yes ___No Date of injury: _____

IF YES: Name of employer: _____ Department: _____

Employer's address: _____ Phone #: (____) _____

City: _____ State: _____ Zip: _____

Contact Person: _____

EMERGENCY CONTACT:

Name: _____ Relationship to you: _____

Home #:(_____) _____ Cell #:(_____) _____

How did you hear about us: _____

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