Patient Registration

Patient Name:_____ Date of Birth:____/____/____

Social Security Number:_____ ☐ Declined Sex: ☐ Male ☐ Female

Address:_____ City:_____ State:_____ Zip:_____

Home Number:_____ Cell Number:_____

Work Number:_____ Email:_____

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

Race: ☐ African American/ Black ☐ American Indian/Alaska Indian ☐ Asian ☐ Caucasian/ White
☐ Native Hawaiian/Pacific Islander ☐ Unspecified

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unspecified ☐ Declined

Preferred Language: ☐ English ☐ Spanish ☐ Other:_____

Emergency Contact:_____ Relationship:_____
Address:_____ Phone Number:_____ DOB:____/____/____

Please indicate which doctor you were referred to see:_____
Optometrist (Eye Doctor):_____ Phone Number:_____
Primary Care Physician (PCP):_____ Phone Number:_____

Preferred Pharmacy:_____ Phone Number:_____
Address:_____ City:_____ State:_____ Zip:_____

Patient Employment: ☐ Employed ☐ Retired ☐ Student ☐ Other:_____
Occupation:_____ Employer:_____ Phone Number:_____

Patient Insurance Information

Please provide the front desk with your current insurance card(s).

Is the insurance in your name? ☐ Yes (Skip SECTION B) ☐ No (Fill out SECTION B below)

SECTION B: Guarantor's Information (person responsible for today's fee's) ☐ Spouse ☐ Guardian ☐ Other

Guarantor Name:_____ Date of Birth:____/____/____

Date of Birth:____/____/____ Social Security Number:_____ Driver's Lic. Number:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Number:_____ Cell Number:_____

Guarantor's Employer:_____ Employer Number:_____