FAMILY EYE GROUP

Patient Registration Form

PATIENT INFORMATION:

Last Name:	First Name:	MI:	Birth Date:
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:		
Email Address:	Age:	Sex ❑ M ❑ F	Social Security #
Occupation:	Employer:	Employer Phone:	
Employer Address:	City:	State:	Zip:
Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced	Spouse's Name:		
Spouse's Birth Date:	Spouse's Social Security #:	Spouse's Employer:	Phone Number:

PLEASE COMPLETE IF PATIENT IS UNDER AGE 18 OR A COLLEGE STUDENT:

Father's Last Name:	Father's First Name:	MI:	Father's Birth Date:
Father's Employer:	Father's Employer Phone:		
Father's Address:	City:	State:	Zip:
Father's Home Phone:	Father's Cell Phone:	Fathers' Social Security #:	
Mother's Last Name:	Mother's First Name:	MI:	Mother's Birth Date:
Mother's Employer:	Mother's Employer Phone:		
Mother's Address:	City:	State:	Zip:
Mother's Home Phone:	Mother's Cell Phone:	Mother's Social Security #:	

REFERRAL INFORMATION:

Name of Optometrist:	Name of Family Physician:
Were you referred here today by any of your physicians? If so, whom?:	

(Please complete back side)

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MEDICARE PATIENTS WHO HAVE PART B:

Medicare Number:	Effective Date:

1. Do you or your spouse work for a company that provides you with health insurance?	❑ Yes	❑ No
2. Are you entitled to Medicare because of disability or End-Stage Renal Disease?	❑ Yes	❑ No
3. Is the illness or injury the result of an automobile accident or other injury?	❑ Yes	❑ No
4. Has the treatment for the accident or illness been authorized by the Veteran's Admin?	❑ Yes	❑ No
5. Are you entitled to any benefits under the Federal Black Lung Program?	❑ Yes	❑ No

PRIMARY INSURANCE

Name of Insurance:	ID Number:
Employer:	Group Number:
Who is the subscriber:	Do you need a referral?: ❑ Yes ❑ No
Subscriber's Date of Birth:	Subscriber's Social Security #:

SECONDARY INSURANCE

Name of Insurance:	ID Number:
Employer:	Group Number:
Who is the subscriber:	Do you need a referral?: ❑ Yes ❑ No
Subscriber's Date of Birth:	Subscriber's Social Security #:

WORKMAN'S COMP. OR AUTO INSURANCE:

Where should bill be sent?:			Phone Number:
Address:	City:	State:	Zip:
Claim or Policy Number:			Date of Injury:

Patient Name: _____ **Date of Birth:** _____

Today's Date: _____