

Today's Date: _____

PATIENT REGISTRATION – Please Print Clearly

 Last Name: _____
 First Name: _____ M.I.: _____
 Date of Birth: _____ Sex: M F
 Social Security #: _____
 Marital Status: S M D W P

 Address: _____
 City: _____ State: _____ Zip: _____
 * Home #: () _____
 * Work #: () _____
 * Cell #: () _____
 *Preferred Point of Contact

Race: American Indian or Alaskan Native
 Asian
 Black or African American
 Native Hawaiian or Other Pacific Islander
 Caucasian

Ethnicity: Hispanic or Latino
 Not Hispanic or Latino

Primary Language: _____

 Employer: _____
 Email Address: _____
 Emergency Contact: _____
 Emergency Phone #: _____

 Occupation: _____
 Referred By: _____
 Relationship to Patient: _____

PRIMARY CARE INFORMATION – Please Print Clearly

 Primary Care Physician: _____ Physician Office #: _____
 Pharmacy Name: _____ Pharmacy #: _____

RESPONSIBLE PARTY/GUARANTOR – If patient is a child or under 18

 Last Name: _____ Employer: _____
 First Name: _____ M.I.: _____ Work #: _____
 Date of Birth: _____ Social Security #: _____ Daytime Phone: () _____
 Address: _____ Cell #: () _____
 Relationship to Patient: Self Spouse Child Parent Other _____

INSURANCE INFORMATION – Please complete this section then give your insurance card & Photo ID to receptionist with the form
Primary Insurance: _____ Policy #: _____
 Policy Holder's Name: _____ Group #: _____
 Date of Birth: _____ SS #: _____ Insurance Phone #: _____

Secondary Insurance: _____ Policy #: _____
 Policy Holder's Name: _____ Group #: _____
 Date of Birth: _____ SS#: _____ Insurance Phone #: _____

ARE YOU COVERED BY A VISION PLAN? VSP DAVIS VISION BLUE VISION OTHER _____

FOR OFFICE USE ONLY

RECEPTIONIST'S INITIALS: _____

 MD DC VA