

REGISTRATION

(PLEASE PRINT)

	Appointment Date:	
Patient:		
Patient:Last Name	First Name	M.I.
Date of Birth:	_	
Street Address:		
City:	State: Z Cell Phone:	ip:
Home Phone:	Cell Phone:	
Home Phone:Email Address:	Social Security:	
	IarriedWidowedSe	eparated
Responsible Party (if a minor):	Relationship: _	
Patient Employed By:		
Patient Employed By:Occupation:	Business Phone:	
Do you have Vision Insurance (covered for a real Name of Insurance Company:	, , , , , , , , , , , , , , , , , , ,	
Primary Care Physician:	Phone:	
In case of emergency, notify:	Phone:	
ASSIGNMENT AND RELEASE: I, the undersigned, have insurance coverage and benefits, if any, otherwise payable to me for ser responsible for all charges whether or not parelease all information necessary to secure the pon all my insurance submissions.	vices rendered. I understand to id by insurance. I hereby auth	hat I am financially orize the doctor to
Signature of Insured/Patient:	Date:	