ASSOCIATES IN EYECARE, P.C.

REGISTRATION FORM

PLEASE PRINT

Name ______________________________ Soc. Sec. # ______________
LAST NAME FIRST NAME INITIAL

Address ______________________________ Home Phone # ______________

City ______________ State _____ Zip Code ______________ Work Phone # ______________

Email: ______________________________ Cell # ______________

Birth Date ______________ Age _____ Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ W ☐ D

Occupation ______________ Employer ______________

Pharmacy Name ______________ Pharmacy Number ______________

Primary Care Physician ______________________________

How did you hear about us? ______________________________

How do you prefer to be contacted? ❑ **Home Phone** ❑ **Cell** ❑ **Email**

Person to be Contacted In Case of Emergency ______________ Relationship To Patient ______________ Phone # ______________

PRIMARY INSURANCE

Insured's Name ______________ Insured's Birth Date ______________ Relationship To Patient ______________

Soc. Sec. # of Insured ______________

Insurance Company ______________ Identification Number ______________ Group Number ______________

SECONDARY INSURANCE

Insured's Name ______________ Insured's Birth Date ______________ Relationship To Patient ______________

Soc. Sec. # of Insured ______________

Insurance Company ______________ Identification Number ______________ Group Number ______________

ASSIGNMENT AND RELEASE

To the best of my knowledge, the above is current and accurate. **I understand that I am financially responsible for all charges not covered by my medical insurance.**
I certify that I (or my dependent) have insurance coverage and assign directly to Associates Eyecare, P.C., all insurance benefits. I authorize the physicians to release all information necessary to secure payment from my insurance company. I authorize use of my signature on all insurance submissions:

Patient/Guardian Signature ______________________________ **Date** ______________