Eastern Sierra Eyecare

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& Associates

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REGISTRATION FORM

Today's Date:						
PATIENT INFORMATION						
Patient's last name: First: Middle:			☐ Mr. ☐ Ms. ☐ Mrs. ☐ Miss	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐		
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):		Birth date:	Age:	Sex: ☐ M ☐ F
Street address:				Social Security no.:		
P.O. Box:		City:	State:	ZIP Code:		
Email Address:		Home phone no.: ( )		Cell Phone ( )		
Occupation:		Employer:		Employer phone no.: ( )		
Chose clinic because/referred to clinic by (Please check one box):	☐ Family ☐ Friend	Name:				
Primary Care Doctor:						

INSURANCE / FINANCIAL INFORMATION			
(Please give your insurance card to the receptionist.)			
Person responsible for bill:	Birth date:	Address (if different):	Home phone no.: ( )
Insurance Company:		Policy no.:	

Copays are due at the time of service. We will inquire about your copay and deductibles and bill your insurance out of courtesy to you. However, it is your responsibility to know your benefits and be sure that you are covered for this visit. *Please initial* _____

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Revised 5-1-2018