CASCADE EYE CENTER

Patient Registration Form

Patient Information

First Name	Middle	Last Name	Preferred Nickname

Date of Birth	Social Security #	Gender ☐ Male ☐ Female ☐ Undefined	Previous Last Name (if applicable)

Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership ☐ Widowed ☐ Divorced ☐ Separated ☐ Other:

Mailing Address	Apt #	City	State	Zip Code

Home Phone	Cell Phone	Work Phone	Preferred Number ☐ Home ☐ Cell ☐ Work

Email	Primary Care Physician	Preferred Pharmacy Name & Location

Employment Status: ☐ Student ☐ Retired ☐ Unemployed ☐ Full-Time ☐ Part-Time ☐ Self-Employed	Employer Name	Occupation

Emergency Contact Name	Emergency Contact Phone #	Relationship to Patient

Alternate Emergency Contact	Alternate Emergency Contact Phone #	Relationship to Patient

How did you hear about us? ☐ Insurance Company ☐ Phone book ☐ Radio ☐ Drive By ☐ Friend/Relative ☐ Web ☐ Other: _____

Responsible Party ☐ Self (all information same as above)

NOTE: If the patient is a minor (under the age of 18) the parent or guardian bringing the patient in will be listed as the guarantor.

First Name	Last Name	Relationship to Patient: ☐ Self ☐ Parent/Guardian ☐ Spouse/Partner ☐ Other:_____

Date of Birth	Social Security #	Phone

Address of Responsible Party	Apt #

City	State	Zip Code

Medical Insurance ☐ Check if no medical insurance

Insurance Company Name	
Policy Holder Name	
Policy Holder's Date of Birth	
Policy Holder's Social Security #	
Group #	Insurance ID #
Patient Relationship to Policy Holder: ☐ Self ☐ Parent/Guardian ☐ Spouse/Partner ☐ Other:_____	

Vision Insurance ☐ Check if no vision insurance

Insurance Company Name	
Policy Holder Name	
Policy Holder's Date of Birth	
Policy Holder's Social Security #	
Group #	Insurance ID #
Patient Relationship to Policy Holder: ☐ Self ☐ Parent/Guardian ☐ Spouse/Partner ☐ Other: _____	

SUMMARY - FINANCIAL POLICY

INSURANCE BILLING and PAYMENTS: We verify and bill your insurance as a courtesy. Insurance verification is not a guarantee of payment. Copies of insurance cards, name, and birth date of insurance subscriber for each family member at each visit are necessary for accurate and timely insurance billing.

PAYMENT: All fees for services not covered and/or paid by insurance including co-payments and deductibles will be the responsibility of the patient or responsible party. Cash, check, money orders, VISA, MasterCard, American Express, and Discover are also accepted. Care Credit is provided as a financing option.

I hereby authorize Cascade Eye Center LLC or their designee(s) to exchange information regarding my care and benefits with the above listed insurance company or companies for the purchase of collecting professional fees on my behalf. I assign all benefits payable to Cascade Eye Center. To the best of my knowledge, this information is accurate as of this date. I accept full responsibility for all charges related to my treatment that are not covered by my insurance.

Signature of Patient/Responsible Party: _____ **Date:**_____