



Patient Registration Form

Patient Information					
First Name		Middle	Last Name		Preferred Nickname
Date of Birth	Social Security #		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undefined		Previous Last Name (if applicable)
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partnership <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Other:					
Mailing Address			Apt #	City	State Zip Code
Home Phone		Cell Phone		Work Phone Preferred Number <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	
Email			Primary Care Physician		Preferred Pharmacy Name & Location
Employment Status: <input type="checkbox"/> Student <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> 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? <input type="checkbox"/> Insurance Company <input type="checkbox"/> Phone book <input type="checkbox"/> Radio <input type="checkbox"/> Drive By <input type="checkbox"/> Friend/Relative <input type="checkbox"/> Web <input type="checkbox"/> Other: _____					
Responsible Party <input type="checkbox"/> 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: <input type="checkbox"/> Self <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Other: _____	
Date of Birth	Social Security #		Phone		
Address of Responsible Party					Apt #
City			State	Zip Code	
Medical Insurance <input type="checkbox"/> Check if no medical insurance			Vision Insurance <input type="checkbox"/> Check if no vision insurance		
Insurance Company Name			Insurance Company Name		
Policy Holder Name			Policy Holder Name		
Policy Holder's Date of Birth			Policy Holder's Date of Birth		
Policy Holder's Social Security #			Policy Holder's Social Security #		
Patient Relationship to Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Other: _____			Patient Relationship to Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> 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:** _____