PATIENT REGISTRATION FORM

KELLY VISION CENTER
(615) 868-2877

PATIENT INFORMATION				
Patient's Name (first, middle, last):		☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.		
Email Address:	Social Security Number:	Birth date: / /	Age:	Sex: ☐ M ☐ F
Street Address:	Home Phone: ( )	Cell Phone: ( )		
City:	State:	Zip code:		
Occupation: ☐ Full-Time ☐ Part-Time		Employer:		
[For Students] School:		Grade:		
Preferred Language:	Ethnicity:	Referred by:		
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced	Spouse Name:	Spouse Cell Phone: ( )		
PRIMARY CARE PHYSICIAN (PCP)				
Name:	Address:	Phone: ( )		
IN CASE OF EMERGENCY				
Emergency Contact:	Relationship:	Phone: ( )		
INSURANCE INFORMATION				
Name of PRIMARY Insurance & ID#:	Name of SECONDARY Insurance & ID#:			
*If you are not the insurance policy holder, please list the policy holder information below				
Insurance Policy Holder Name (first, middle, last):	Relationship to Insured:	Birth date: / /	Age:	Sex: ☐ M ☐ F
Street Address:	Social Security Number:	Cell Phone: ( )		
City:	State:	Zip code:		
PHARMACY				
Name:	Street Address, City, State, Zip Code:			

1. I give permission for Dr. Kelly to discuss my visit with my guardian or spouse or other (listed below).
   Other (name): _____ Phone: (____)_____
   Patient or Guardian Signature:_____ Date: _____
2. I give permission for Dr. Kelly to release records to my doctor(s) upon their request.
   Patient or Guardian Signature:_____ Date: _____
3. I request that payment of authorized insurance benefits or any other third-party payer be made to me or on my behalf to Dr. Marie C. Kelly and/or its independent contractor for any services furnished by the provider. I authorize any holder of medical information about me to release to the agents or any third-party payers any information needed to determine these benefits or the benefits payable for related services.
   Patient or Guardian Signature:_____ Date: _____