Patient Registration Form

PATIENT INFORMATION

NAME (Last, First, MI) _____

ADDRESS_____

CITY_____ STATE _____ZIP CODE _____

PHONE: Please check box next to best number to call

- ☐ Home ( )_____
- ☐ Cell ( )_____
- ☐ Work ( )_____

DATE OF BIRTH_____ SOCIAL SECURITY #_____

SEX M F MARITAL STATUS_____

EMAIL_____ OCCUPATION_____

GUARDIAN INFORMATION *(If patient is under 18 years of age)*

First Name_____
Last Name_____
Daytime Phone_____
Cell Phone_____
Email_____

Mailing Address_____
Suite/Apt._____
City_____
State_____
Zip Code_____

INSURANCE INFORMATION

-Medical Insurance-

Primary_____
Member's Name_____
Member's DOB_____
ID #_____

Secondary_____
Member's Name_____
Member's DOB_____
ID #_____

-Vision Insurance-

Primary_____
Member's Name_____
Member's DOB_____
ID #_____

Secondary_____
Member's Name_____
Member's DOB_____
ID #_____

EMERGENCY INFORMATION

In case of emergency please notify: _____

PHONE # ( )_____ Relationship to patient_____

REFERRED BY:_____

FINANCIAL RESPONSIBILITY

I permit a copy of this authorization to be used in place of the original, and request payment of insurance benefits to Carolina Vision Care. I understand and accept financial responsibility for all and any service rendered to me. I understand my insurance company is billed as a courtesy to me and payment of any bill is my responsibility.

PATIENT OR GUARDIAN SIGNATURE_____DATE_____