EYE SURGEONS ASSOCIATES
PATIENT REGISTRATION FORM
Please review, make necessary changes and complete any missing information

Patient First			**Middle**	**Last**	
Birth date		**Sex**	**SS# (Required)**		
Address		**City**	**State**	**Zip**	
Marital Status	S M W D	**Employer (Required)**			

COMMUNICATION					
Appt Reminder Preference		**Email Address**			
Home Phone #		**Work Phone #**		**Ext**	
Cell Phone #					

INFORMATION			
Primary Language		**Special Needs**	
Race		**Ethnicity**	

ACCOUNT RESPONSIBLE (if different from patient)						
Responsible				**Relationship**		
Birth date		**SS# required**		**Employer required**		
Address						
Home Phone #		**Cell Phone#**		**Work Phone#**		**Ext**

PRIMARY INSURANCE			
Name		**Copay**	$
ID #		**Group #**	
Address		**Phone**	
Insured		**Date of Birth**	

SECONDARY INSURANCE			
Name		**Copay**	$
ID #		**Group #**	
Address		**Phone**	
Insured		**Date of Birth**	

VISION INSURANCE

Vision Insurance Plan_____ Subscriber_____ ID#_____
If you wish to use your Vision benefits for today's visit, please circle the reason for your visit and sign and date below
routine eye exam new glasses or contacts need new prescription

Signature_____Date_____

EMERGENCY CONTACTS

First	Last	Relationship	Home#	Cell#	Work#	Ext

For new patients, who referred you? **Family/Friend OD/PCP Website Yellow Pages Web Search Other**

The undersigned hereby assign and request that payment of all medical, vision and/or worker's comp benefits be made to Eye Surgeons Associates. I authorize the release of all medical and other information that is necessary to process claims. Furthermore, I understand that I am financially responsible for any and all non-covered charges incurred while under the care of said physician, including co-payments, co-insurance and/or deductibles. It is also acknowledged that any unpaid balances may be subject to collections and is the responsibility of the guarantor.

_____ _____
Patient or Guarantor Signature Date