Today's Date _____ **Patient Registration** Chart # _____

Patient's Name (last, first, middle initial)	Date of Birth	Sex	Home Phone
			Cell Phone
Street Address	City	State / Zip	Work Phone
Is Patient? Single [ ] Married [ ] Widowed [ ] Divorced [ ] Full-time Student [ ] Part-time Student [ ]			Social Security #
Race: _____	Email: _____		
Ethnicity: Hispanic [ ] Non-Hispanic [ ] Other [ ]	Language: English [ ] Spanish [ ] German [ ] Other [ ]		
Emergency Contact Name (with different phone number)	Relationship	Phone #	
Referring Physician	Family Physician		
Employer's Name	Street Address	Is patient's condition related to? A. Employment [ ] B. Auto Accident [ ] C. Other Accident [ ]	
Business Phone / City / State / Zip		If yes, explain _____	
Spouse Name (last, first, middle) / Date of Birth	Social Security #	Date of accident _____	
Spouse's Employer	Business Phone		

If patient is a child, please complete:

Father's Name	Street Address	Home Phone
SS # / DOB	City / State / Zip	Work Phone
Mother's Name	Street Address	Home Phone
SS # / DOB	City / State / Zip	Work Phone

Complete the Insurance information below

Insurance Company	Insured's DOB	Contract Number	Group
Insured's Name	Insured's SS#	Relationship to Paitent	Does coverage include vision?
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Insured's Name	Insured's SS#	Relationship to Paitent	Does coverage include vision?

* Most health insurances do NOT cover routine vision care. Vision insurance covers only routine care. If you have any questions as to whether your insurance will cover your visit, please ask.

Please complete back of form!

Parental Consent for the Treatment of a Minor

Please be advised that anyone seeking medical treatment or routine eye care under the age of 19 is required to have parental consent. This consent must be given by a parent or legal guardian. Your signature below gives us consent to provide the necessary medical care and/or vision care deemed necessary by the physician providing the care.

By signing below you additionally accept financial responsibility for the treatment of the dependant child. All co-pays and/or fees are the responsibility of the guarantor presenting the minor for services/treatment regardless of any legal and/or verbal agreement between the parents.

Patient's Name	Guarantor's Signature	Guarantor's DOB
Relationship of guarantor	Guarantor's Social Security #	Today's Date	M / F Sex of the guarantor