ASSOCIATES IN EYECARE, P.C.

REGISTRATION FORM

PLEASE PRINT

Name _____ Soc. Sec. # _____
LAST NAME FIRST NAME INITIAL

Address _____ Home Phone # _____

City _____ State _____ Zip Code _____ Work Phone # _____

Email: _____ Cell # _____

Birth Date _____ Age _____ Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ W ☐ D

Occupation _____ Employer _____

Pharmacy Name _____ Pharmacy Number _____

Primary Care Physician _____

Who may we thank for referring you? _____

Person to be Contacted In Case of Emergency _____ Relationship To Patient _____ Phone # _____

PRIMARY INSURANCE

Insured's Name _____ Insured's Birth Date _____ Relationship To Patient _____

Soc. Sec. # of Insured _____

Insurance Company _____ Identification Number _____ Group Number _____

SECONDARY INSURANCE

Insured's Name _____ Insured's Birth Date _____ Relationship To Patient _____

Soc. Sec. # of Insured _____

Insurance Company _____ Identification Number _____ Group Number _____

ASSIGNMENT AND RELEASE

To the best of my knowledge, the above is current and accurate. **I understand that I am financially responsible for all charges not covered by my medical insurance.**
I certify that I (or my dependent) have insurance coverage and assign directly to Associates Eyecare, P.C., all insurance benefits. I authorize the physicians to release all information necessary to secure payment from my insurance company. I authorize use of my signature on all insurance submissions:

Patient/Guardian Signature _____ **Date** _____