PATIENT REGISTRATION – Des Peres Eye Center

Patient Name _____ Today's Date _____
Last First Middle

Home Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

E-mail address _____ Marital Status Single Married Divorced Widowed

Social Security Number _____ Date of Birth _____ Age _____ Gender M F

Employer/Parent's Employer _____ Occupation _____

Work Address _____ Work Phone _____

City _____ State _____ Zip Code _____

Spouse name (Parent name if minor) _____ Spouse/Parent Work Phone _____

Person to notify in case of emergency (other than spouse) _____

Phone number (s) _____ Relationship _____

Your Pharmacy Name, Address & Phone: _____

VISION Insurance: _____ **ID#:** _____ **Subscriber Name:** _____ **DOB:** _____

Primary Medical Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		**Relationship to Patient**
Social Security Number	Date of Birth	Employer

Secondary Medical Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		**Relationship to Patient**
Social Security Number	Date of Birth	Employer

I certify that all above information is true and accurate, and I authorize the release of any medical or other information necessary to file and process my insurance claims. I understand all medical information provided will be kept strictly confidential and will only be released to me or at the request of my insurance company.

_____ _____

Patient's signature **Today's date**