WASHINGTON EYE SPECIALISTS

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Email:			

Birth date:	Sex:	Age:

Street address:	Social Security no.:	Home phone no.: ( ) ( )

Apt:	City:	State:	ZIP Code:

Pharmacy Name:	Address:	Phone:

Race Ethnicity (please check one box): White ❑ Asian ❑ Hispanic or Latino ❑

Black or African American ❑ American Indian/Alaska Native ❑ Other ❑

INSURANCE INFORMATION

(Primary Insurance)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Washington Eye Specialists or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*