

Patient Registration Form
The Center for Eye Care and Optical

Please complete the information below and print out the completed form and bring it with you when you come to our office.

Name _____

Address _____ City _____ State _____ Zip _____

Date of Birth ___ / ___ / ___ Home Phone() _____ Cell Phone() _____

Work Phone() _____ Occupation _____

SS# _____ Employer _____

How were you referred to the office?

- | | |
|--|--|
| <input type="checkbox"/> Friend or Family Member | <input type="checkbox"/> Ins Company |
| <input type="checkbox"/> Family Doctor | <input type="checkbox"/> Internet |
| <input type="checkbox"/> Phone Book | <input type="checkbox"/> Ophthalmologist |

If referred by Family Doctor or Optometrist specify name _____

Primary Insurance Information	Secondary Insurance Information
Insurance Company Name	Insurance Company Name
Employer	Employer
Identification Number	Identification Number
Group Number	Group Number
Name of Policy Holder	Patient's Relation to Insured
Insured's Date of Birth	Insured's Date of Birth
Insured's S.S.#:	Insured's S.S.#:
Tertiary Insurance	
Insurance Company Name	
Identification Number	

We fill claims as a courtesy to our patients. If you do not have insurance in which we participate, payment is expected at the time services are rendered. Any applicable co-payments and deductibles are also due at each visit.

Patient Signature _____