

Eye Physicians & Surgeons, LTD.

PATIENT REGISTRATION

Appointment Date: _____

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home phone: _____ Work phone: _____ Cell: _____

Date of Birth: _____ Sex: M ___ F ___ Social Security # _____ - _____ - _____

E-mail: _____ Occupation: _____

Marital Status: Married ___ Single: ___ Other: ___ Age: _____

Employer/School: _____ Employed: ___ Retired: ___ Student: ___

Primary Physician: _____ Phone #: _____

Emergency Contact Person: _____ Phone #: _____

Who referred you to our office? _____

Are you planning to get new glasses? Yes ___ No ___

Are you planning to get new contacts? Yes ___ No ___

Are you interested in finding out more about laser vision correction? Yes ___ No ___

INSURANCE INFORMATION

Last Name of Policy Holder: _____ First: _____ MI. _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Sex: M ___ F ___ Social Security # _____ - _____ - _____

Policy Holder's Phone # _____ Employer: _____

Relationship to Policy Holder: Self ___ Spouse ___ Dependent _____

The information below is good for 12 months following the date signed. On an advisory from the American Academy of Ophthalmology, it is necessary to document the fact that you have been advised about the blurring of vision that may occur because of the dilation drops used to examine your eyes. These drops may make both walking and driving more difficult or dangerous. Not to dilate your eyes may result in an inadequate examination. The need for dilation is based on the judgment of the Physician.

**I am financially responsible for all co-payments, deductibles or amounts not covered by my insurance.*

Patient's Signature: _____ Date: _____

Patient's Signature: _____ Date: _____

Patient's Signature: _____ Date: _____