



Patient Registration

PATIENT NAME: (Last) _____ (First) _____ (MI) _____ CHART #: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

PHONE(S) #: Home: _____ Cell: _____

EMAIL: _____

PRIMARY CARE DOCTOR: _____

EYE DOCTOR: _____

IS TODAY'S VISIT WORK COMP RELATED: (circle one) YES NO

(If yes, please request additional paperwork from receptionist.)

PRIMARY INSURANCE CARRIER: _____

(Please provide copy of all insurance cards to receptionist.)

SECONDARY INSURANCE CARRIER: _____

HIPAA RELEASE / POA INFO - WHO ARE WE ALLOWED TO SPEAK TO?

NAME: _____ RELATIONSHIP: _____ PHONE #: _____

NAME: _____ RELATIONSHIP: _____ PHONE #: _____

OTHER REQUIRED MEDICARE QUESTIONS

Are you currently in hospice care? (circle one) YES NO

If you have Medicare, is it: (circle one) PRIMARY SECONDARY

Are you disabled? (circle one) YES NO

Is your spouse working? (circle one) YES NO N/A

Are you in End Stage Renal Failure? (circle one) YES NO

Are you currently in a nursing facility? (circle one) YES NO

Name of Facility: _____ Phone #: _____

Address: _____

Level of Care: (circle one) RESIDENTIAL INDEPENDENT ASSISTED ICF SKILLED

SIGNATURE: _____ DATE: _____

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