Quick Patient Registration Form - Ophthalmology

Patient Information:

Legal First Name: _____MI: ___ Legal Last Name:_____

Sex: M F **Date of Birth:**_____ **Age** ____ **Primary Language:**_____

Marital Status: Married Single Partner Divorced Widowed

Race: _____ **Ethnicity:** _____

_____ _____ _____ _____

Address City State Zip Code

_____ _____ _____ _____

Home phone Cell phone Work phone Email

Preferred method of contact (circle one): Home Phone Cell Phone Work Phone Email
Would you like access to the patient Portal? Y N **May we text you?** Y N

Patient Insurance:

Insurance Information: Are you the Primary Cardholder: Y N

If No: Name of Cardholder:_____ Relationship_____ DOB _____

Do you have a Secondary Insurance: Y N

Name of Cardholder:_____ Relationship_____ DOB _____

Ophthalmology-Specific:

Do you wear glasses? Y N Do you wear contact lenses? Y N If yes, what brand of contacts do you wear? _____ What is the Power? _____ Base Curve _____ Diameter _____

What is your occupation? _____

Pharmacy Preference:	Imaging Facility Preference:	Lab Preference
Name: _____	Name:_____	Name:_____
Address: _____	Address: _____	Address: _____
Phone: _____	Phone: _____	Phone: _____

Authorization to Discuss Health Information with Others and/or Leave Telephone Messages:

I **If we are unable to reach you when we telephone**:

- May we leave such information on your answering machine? Y N
- If you provided a work number, may we contact you at work? Y N
- May we leave such information with another individual? Y N
  - **If Yes**, please note specifically who: _____
  - Relationship to patient_____ Contact phone number: _____
- Is there someone you have given authority to schedule, confirm or cancel appointments for you? Y N
  - **If Yes**, please specify who: _____
  - Relationship to patient_____ Contact phone number: _____

Patient Signature:_____Date/Time _____