DR SUN EYE CARE

REGISTRATION FORM

Today's date:		Appt time: _____ AM/ PM	Family Doctor:	

PATIENT INFORMATION

Patient's last name:	First name:	Middle:	Birth date:	Age:	Sex:
			_ _/_ _/_ _ _ _		❑ M ❑ F

Street address:	Social Security No.:	❑ Home phone No.:
		( )-

City, State ZIP Code	❑ Cell phone:	❑ Work phone:	❑ Email: _____@
	( )-	( )-	_____

Referred to us by (please check one box):	❑ Dr. ( )	❑ Insurance Plan

❑ Family	Other family members seen here:		
❑ Friend ( )	❑ Internet	❑ Newspaper	❑ Close to home/work

INSURANCE INFORMATION

(Please give your insurance card to our staff)

Is this patient covered by insurance? ❑ Yes ❑ No

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

Is this person a patient here? ❑ Yes ❑ No

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

Primary insurance:

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

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

Secondary insurance (if applicable):

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

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

Vision Plan (if applicable):

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

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

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Contact 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 have read the Privacy Notice of Dr Sun Eye Care and understand it. I consent to the use and disclosure for my health information for purpose of treatment, payment and health care operations.

Patient/Guardian signature *Date*