# PATIENT REGISTRATION FORM

## PLEASE PRINT

Patient Name (Last, First, M)_______________________________________________________________ Birthdate ___/___/________ Age ______

Social Security # ___________________________ Please Circle: Male/Female Single/Married/Divorced/Widowed Student: Yes/No

Mailing Address ______________________________________________________________________________________________

City __________________________________________________ State _____________________ Zip Code _______________________________

Home Phone Number ______________________________ Cell Phone Number ________________________________________________________

Email ____________________________________________________________________________________________________________

Employer __________________________________________________________ Work Phone Number ______________________________________

Emergency Contact ___________________________________Relation _________________________ Phone Number _________________________

If referred: [ ] Radio [ ] Phone Book [ ] Doctor _____________________________[ ] Newspaper [ ] Other ____________________________

Preferred method of contact: (Check all that apply) ❑ Home phone ❑ Cell phone ❑ Text ❑ Email ❑ Snail Mail ❑ Work phone

**For Minor Patients:**

Responsible Party ____________________________________________________________________________________________

Relation ______________________________ Date of Birth __________________________ Phone Number __________________________________

Mailing Address (if different than above) ___________________________________________________________________________

City __________________________________________________________ State _______________________ Zip Code ________________________

**Primary Insurance Information:**

Name of Policy Holder (if different from above): ______________________________________________ Policy Number ________________________

Insurance Company Name _________________________________________________________________ Phone Number _______________________

Address (City, State, Zip Code) ________________________________________________________________________________

Policy Holder's Date of Birth ___________________ Policy Holder's SSN# ________________________Employer ____________________________

Group # ________________

**Secondary Insurance Information:**

Name of Policy Holder (if different from above): ______________________________________________ Policy Number ________________________

Insurance Company Name _________________________________________________________________ Phone Number _______________________

Address (City, State, Zip Code) ________________________________________________________________________________

Policy Holder's Date of Birth ___________________ Policy Holder's SSN# ________________________Employer ____________________________

Group # ________________

**We will make a copy of your insurance card(s) at the front desk.**

**It is the patient's responsibility to verify insurance benefits. We will bill the insurance as a courtesy to the patient. Without complete insurance information, we have no alternative but to send the bill to the patient. I give The Eye Institute of Wyoming, P.C. permission to bill my insurance on my behalf and assign to The Eye Institute of Wyoming, P.C. directly all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I agree to remit payment to The Eye Institute of Wyoming, P.C. in a timely manner. I understand that any unpaid balance may be turned over to an agency for collections and I will be responsible for any fees that they charge to collect the unpaid balance. If you do not wish for us to bill your insurance, or if you do not have insurance, payment in full is expected on the day of the exam (50% deposit required for optical services).**

**Patient Signature (or signature of responsible party)** ______________________________________________________ **Date** _________________