

Fromer Eye Centers

REGISTRATION FORM

Today's Date _____

Mr. Mrs. Ms. Dr.

Last Name _____ First Name _____ Middle Initial _____

Male Female

Birth Date _____ Age _____

Social Security Number _____ Email Address _____

Home Phone _____ Cell Phone _____ Misc. Alternate Phone _____

Street Address _____

Apartment Number _____

City _____ State _____ Zip Code _____

Occupation/Employer _____

Work Phone _____

Primary Care Physician's Name (PCP) (First + Last Name) (REQUIRED) _____

PCP's Address _____ PCP Phone Number _____

Referred to us by: Physician Family/Friend Insurance Plan Hospital Internet/Google Search Other _____

In case of an emergency, please contact:

Name of local relative or friend Relationship to you

Contact's Home Phone Contact's Work Phone

*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 also authorize Former Eye Centers or insurance company to release any information required to process my claims. **Payment is expected at the time of visit unless we participate with your insurance plan. Any copayment required under your plan is due at time of visit. I have received the Notice of Privacy Practices and I have had an opportunity to review it, and take a copy for my records if I request to do so.***

X _____
PATIENT/GUARDIAN SIGNATURE

DATE

Pharmacy Name _____

Pharmacy Address _____

Pharmacy Telephone #: _____