Fromer Eye Centers REGISTRATION FORM

Today's Date: _____

Last Name **First Name** **MI**

Mr._____ Mrs.____ Ms._____ Dr.____

_____ Male_____ Female _____

Date of Birth Age

Race: [ ] African American [ ] Asian [ ] Caucasian [ ] Hispanic [ ] Native American [ ] Other

Ethnicity: _____

Primary Language: _____

Social Security Number **E-Mail Address**

Pharmacy Name: _____

Street Address

Pharmacy Address:_____

Apartment Number

Pharmacy Telephone: _____

City State Zip Code

Primary Phone **Secondary Phone**

Occupation/Employer **Work Phone Number**

Primary Care Physician's Name (PCP) (REQUIRED)

PCP's Address **PCP's Telephone Number**

Referring Physician: _____

First Name Last Name Address/ Telephone Number

In case of an emergency, please contact: _____

Name of Person **Relationship to you**

Contact's Primary Phone **Contact's Secondary 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 Fromer Eye Centers or insurance company to release any information required to process my claims and comply with any medical record requests made by my insurance. Payment is expected at the time of the 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.

X_____

PATIENT/GUARDIAN SIGNATURE **DATE**