

PATIENT REGISTRATION

Florida Eye Health The Aesthetic & Cosmetic Laser Center
Suncoast Surgery Center The Center for Laser Vision Correction

Please bring this form with you to
your first appointment.

Last Name _____ First _____ MI _____

Local Address _____

City _____ State _____ Zip _____

Home Ph: _____ Work Ph: _____ Cell Ph: _____

SS# _____ Date of Birth _____ Age _____

Sex M F Marital Status S M D W

E-mail Address _____ I give permission to receive emails.

Employed By _____ Position _____

Spouse's Name _____ Spouse SS# _____ DOB _____

Are you a year round resident? Yes No

If not, please circle months that you are in Florida:
Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec

Northern Address _____

City _____ State _____ Zip _____ Phone _____

RESPONSIBLE PARTY (If patient is responsible, please put SAME on Last Name line.)

Last Name _____ First _____ MI _____

Address _____

Relationship to Patient _____ Phone _____

EMERGENCY CONTACT PERSON (other than someone at same address)

Name _____ Relationship _____

Home Phone _____ Work Phone _____

REFERRAL INFORMATION Whom may we thank for referring you to our office? _____

- | | | | |
|--|--|--|--------------------------------------|
| <input type="checkbox"/> My optometrist | <input type="checkbox"/> My insurance plan | <input type="checkbox"/> Seminar | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> My family physician | <input type="checkbox"/> Television | <input type="checkbox"/> Web site/internet | |
| <input type="checkbox"/> Family/patient/friend | <input type="checkbox"/> Newspaper | <input type="checkbox"/> Yellow Pages | |

PROVIDERS

Current Eye Doctor _____ City _____

Primary Care Physician _____ City _____

Pharmacy _____ Location _____

INSURANCE INFORMATION (We will copy the front/back of your insurance cards)

Medicare # _____ Medicaid # _____

Are you retired working If retired, is Medicare your primary insurance? YES NO

PRIMARY Insurance _____

Policy Holder's Name: _____ SS# _____ DOB: _____

SECONDARY Insurance _____

Policy Holder's Name: _____ SS# _____ DOB: _____

VISION Insurance _____

Policy Holder's Name: _____ SS# _____ DOB: _____

ADVANCE DIRECTIVE: If you wish for us to have a copy of your advance directive, please provide it to us. Should it be necessary for you to be transferred to the hospital, this advance directive would accompany you to the hospital.

I acknowledge that the information stated above is true to the best of my knowledge.

Signature

Date