PATIENT REGISTRATION

Frantz EyeCare

Last Name _____ First _____ MI _____ Nickname _____
Local Address _____
City _____ State _____ Zip _____
SS# _____ - _____ - _____ Date of Birth _____ / _____ / _____ Sex ☐ M ☐ F
Marital Status S M D W Race _____ Ethnicity _____
Mother's Maiden Name _____ Birth State _____
Communication preference _____ E-mail Address _____
Home Ph (_____) _____ - _____ Work Ph (_____) _____ - _____ Cell Ph (_____) _____ - _____
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 (Leave Blank if patient is responsible)

Last Name _____ First _____ MI _____
Address _____
Relationship to Patient _____ Phone (_____) _____ - _____
Email_____ SS# _____ - _____ - _____

EMERGENCY CONTACT PERSON (other than someone at same address)

Name _____ Relationship _____
Home Ph (_____) _____ - _____ Work Ph (_____) _____ - _____ Cell Ph (_____) _____ - _____

INSURANCE INFORMATION (Please provide insurance cards so we may scan into your file)

Are you retired ☐Yes ☐No

PRIMARY Insurance _____ Policy Holder's Name _____
SECONDARY Insurance _____ SS# _____ - _____ - _____
VISION Insurance _____ 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.

ACKNOWLEDGMENT OF RECEIPTS OF NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received and had an opportunity to ask questions concerning Frantz Eyecare's Privacy Practices.

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

_____ _____ / _____ / _____
Signature Date