SEIDENBERG PROTZKO EYE ASSOCIATES PATIENT REGISTRATION

PATIENT NAME _____ SOCIAL SECURITY # _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

DATE OF BIRTH _____ AGE _____ SEX ❒ MALE ❒ FEMALE

E-MAIL ADDRESS _____

MARITAL STATUS ❒ MARRIED ❒ SINGLE ❒ WIDOWED ❒ DIVORCED

LANGUAGE: ❒ ENGLISH ❒ SPANISH ❒ OTHER

ETHNICITY: ❒ HISPANIC OR LATINO ❒ NOT HISPANIC OR LATINO

RACE: ❒ AFRICAN AMERICAN ❒ ALASKA NATIVE ❒ AMERICAN INDIAN ❒ ASIAN/INDIAN

❒ CAUCASIAN ❒ MULTIRACIAL ❒ NATIVE HAWAIIAN ❒ OTHER PACIFIC ISLANDER ❒ OTHER

HEALTH CARE PROVIDERS:

PRIMARY CARE DOCTOR _____

PHONE _____

OPTOMETRIST _____

PHONE _____

EMPLOYMENT:

EMPLOYER _____

OCCUPATION _____

STREET ADDRESS _____

CITY_____ STATE _____ ZIP _____

RESPONSIBLE PARTY (IF SOMEONE OTHER THAN THE PATIENT)

NAME _____ SOCIAL SECURITY # _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

DATE OF BIRTH _____ AGE _____ SEX ❒ MALE ❒ FEMALE

HOW DID YOU HEAR ABOUT US? (Please select only the most influential)

- ❒ Yellow Pages
- ❒ Insurance Provider Directory
- ❒ Newspaper Ad (Please Specify) _____
- ❒ Radio Ad (Please Specify) _____
- ❒ Referred By Family/Friend (Please Specify Name) _____
- ❒ Referred By Physician (Please Specify Name) _____
- ❒ Referred By Optometrist (Please Specify Name) _____
- ❒ Other (Please Specify: Internet, Screening, Etc.) _____

INSURANCE INFORMATION (Please present all insurance cards for copying)

Primary Insurance _____ Policy # _____ Grp # _____

Subscriber _____ Relationship _____

Subscriber's Social Security # _____ Subscriber's Date of Birth _____

Secondary Insurance _____ Policy # _____ Grp # _____

Subscriber _____ Relationship _____

Subscriber's Social Security # _____ Subscriber's Date of Birth _____

I hereby authorize Seidenberg Protzko Eye Associates to bill my insurance which may include release of medical information to process the claim. I also authorize payment to be made directly to Seidenberg Protzko Eye Associates.

SIGNATURE _____ DATE _____