Weston Eye Center and/or Vision Surgery & Laser Center, LLC

REGISTRATION FORM

Today's date:

Account Number:

	Primary Care Physician:		
Patient's name:			
Patient's address:	Birth date:	Age:	Sex:
Phone Numbers & Email: **( )** **Cell Phone:** **( )** **Email Address:**			

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

PRIMARY ADDRESS

POLICY GROUP

SECONDARY ADDRESS

GUARANTOR GUARANTOR DOB

Who may we thank for referring you: ❑ Patient _____

❑ TV	❑ Newspaper	❑ Yellow Pages	❑ Phone Book	❑ Other
❑ Dr. _____			❑ I am currently a patient	

Occupation:	**Employer:**	**Employer phone no.:**
		( )

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

I give my permission for affiliates of Weston Eye Center to speak to the following regarding my care:

NAME_____RELATIONSHIP_____

NAME_____RELATIONSHIP_____

Signature _____ Date : _____