Patient Registration

Patient Name		**(Please Circle) Mr., Mrs., Ms., Dr.**	
Date of Birth		**Age**	
Sex		**SS #**	
Address			
City, State and Zip Code			
How did you hear about us?(circle one): Doctor Friend/Family Internet Facebook Other:___________			

Communication					
Preference: (Please circle) **Home Phone / work phone / cell phone / email / U.S. mail**					
Home Phone #		**Work Phone #**		**Extension**	
Cell Phone #		**Cell Phone Carrier**			
Email					

Information				
Primary Language		**Special Needs**		
Race: (Please circle) American Indian or Alaska Native Asian / Black or African American / Native Hawaiian or other Pacific Islander / White / Decline to specify		**Ethnicity:** Not Hispanic or Latino Hispanic or Latino Decline to specify		
Marital Status: (Please circle) **Married Widowed Single Divorced Separated**				
Occupation		**Employer**		
Business Address			**Work Phone**	

Insurance Subscriber/Policy Holder					
Responsible			**Date of Birth**		
Relationship			**SS #**		
Address					
Home Phone #		**Work Phone #**		**Extension**	
Email					

Emergency Contact				
Name	**Home#**	**Cell#**	**Work#**	**Relationship**

I hereby authorize Eye Physicians of Elizabethtown, PSC to furnish my insurance company all information which my insurance company may request concerning my illness or injury. I hereby authorize payment directly to Eye Physicians of Elizabethtown, PSC for medical and/or diagnostic benefits, including payment for any major medical benefits for services rendered during the course of treatment. I fully understand that I am obligated to pay the physician the balance due after insurance adjustment has been made and any collection fees incurred. I also understand that I am responsible for knowing the benefits of my insurance policy. I permit a copy of this authorization to be used.

Signature ____Date ____________________