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? ______________________

❑ My optometrist ❑ My insurance plan ❑ Seminar ❑ Other_______________
❑ My family physician ❑ Television ❑ Web site/internet
❑ Family/patient/friend ❑ Newspaper ❑ 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:___________

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

____ ______________________________
Signature **Date**