PATIENT REGISTRATION

Please bring this form with you to your first appointment.

Florida Eye Health
The Aesthetic & Cosmetic Laser Center
The Center for Laser Vision Correction
Suncoast Surgery Center

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 _____

Northern 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)

I. Name _____ Relationship _____

Home Phone _____ Work Phone _____

(Please turn over and complete other side)

REFERRAL INFORMATION

Whom may we thank for referring you to our office? _____

❑ My optometrist
❑ My family physician
❑ Family/patient/friend
❑ Television
❑ My insurance plan
❑ News-Press
❑ Naples Daily News
❑ Town paper
❑ Radio
❑ Other_____
❑ Seminar
❑ Web site
❑ Coupon/Mail
❑ Yellow Pages

PROVIDERS

Current Eye Doctor:_____

Primary Care Physician:_____ Ph:_____

Address:_____ State:_____ Zip:_____

Pharmacy:_____Ph:_____

Address:_____ State:_____ Zip:_____

INSURANCE INFORMATION (We will copy the front/back of your insurance cards)

Medicare # _____ Medicaid # _____

Are you retired? ❑ YES ❑ NO Retirement Date _____

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:_____

MEDICAL RECORDS RELEASE

I authorize ❑ all my health information ❑ restricted information including: _____
to be released to: (i.e. spouse, family member, etc.)

Name:_____Relationship:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____

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

_____ _____

Signature Date