Patient Registration

APPT DATE_____ TIME_____ DOCTOR_____

We have reserved this time and date for your appointment. If you are unable to make this appointment, please call (620) 275-7248 as soon as possible to reschedule. If you arrive more than 15 minutes late for your appointment, you may be asked to reschedule.*

NAME_____ SOCIAL SEC #_____

D.O.B____/___/____ AGE_____ MALE/FEMALE SINGLE___ MARRIED___ WIDOWED___ DIVORCED___

MAILING ADDRESS_____

CITY_____ STATE_____ ZIP_____

HOME # _____ WORK #_____ CELL # _____

EMAIL ADDRESS _____

EMPLOYER _____

NAME OF NURSING HOME (IF APPLICABLE)_____

NURSING HOME PHONE # _____

GOVERNMENT RELATED QUESTIONS:

RACE: WHITE____ HISPANIC____ AMERICAN INDIAN / ALASKAN NATIVE____ ASIAN____

BLACK / AFRICAN AMERICAN____ HAWAIIAN or other PACIFIC ISLANDER____ DECLINE TO SPECIFY____

ETHNICITY: HISPANIC/LATINO____ NOT HISPANIC/LATINO____ UNKNOWN____ DECLINE TO SPECIFY____

PREFERRED LANGUAGE_____

SPOUSE INFORMATION:

NAME_____ SOCIAL SEC #_____

D.O.B____/____/____ BEST CONTACT # ( ) _____

OPTOMETRIST:

NAME OF OPTOMETRIST_____ PHONE # ( ) _____

PRIMARY CARE PHYSICIAN_____

PHARMACY_____ **CITY**_____

(OVER)

PARENT'S INFORMATION:

IF PATIENT IS A CHILD, WHO IS FINANCIALLY RESPONSIBLE? _____

FATHER'S NAME_____ MOTHER'S NAME_____

HOME ADDRESS_____ HOME ADDRESS_____

WORK PHONE # ( ) _____ WORK PHONE # ( ) _____

CELL # ( ) _____ CELL # ( ) _____

SOCIAL SEC #_____ SOCIAL SEC #_____

D.O.B ___/____/_____ D.O.B ____/____/_____

INSURANCE INFORMATION:

*****PLEASE PRINT NAME AS IT APPEARS ON YOUR PRIMARY INSURANCE CARD*****

NAME OF POLICY HOLDER_____ D.O.B ____/____/____

MEDICARE NUMBER_____ MEDICAID NUMBER_____

OTHER MEDICAL INSURANCE_____

IDENTIFICATION #_____ GROUP #_____

WORKMAN'S COMPENSATION:

DID ACCIDENT HAPPEN AT WORK? (Circle one) **YES** **NO** DATE OF INJURY _____

IF YES: NAME OF EMPLOYER_____ DEPT_____

EMPLOYER'S ADDRESS_____ PHONE # ( ) _____

CITY_____ STATE_____ ZIP_____

CONTACT PERSON_____

EMERGENCY CONTACT:

****NAME OF FRIEND/RELATIVE THAT DOES NOT LIVE WITH YOU THAT WE MAY CONTACT IN AN EMERGENCY****

NAME_____ RELATIONSHIP TO YOU_____

HOME PHONE # ( ) _____ CELL # ( ) _____

HOW DID YOU HEAR ABOUT US?

☐ Referring Provider ☐ Facebook / Web Search

☐ Family / Friend /Word-of-Mouth ☐ Newspaper / Flyer

☐ Radio Advertisement ☐ Other: _____