THE EYE GROUP ASSOCIATES PC & THE EYE GROUP DISPENSARY LLC

PATIENT INFORMATION REGISTRATION FORM

ACCT #_____

PERSONAL:

Name:_____

Address:_____

City State Zip

Phone #s:_____/_____/_____

Home Work Cell

Date of birth:_____SSN:_____Employer:_____

Spouse/Partner_____SSN:_____Date of Birth:_____

Primary Care Physician_____Phone_____

INSURANCE:

PRIMARY Insurance_____ID# _____

Subscriber name_____Group #_____

Relationship to patient: Self Spouse Father Mother Domestic Partner

REQUIRES PCP REFERRAL: ***YES*** ***NO*** ***Insurance coverage***: **Medical** **Vision**

SECONDARY Insurance:_____ID #_____

Subscriber name_____Group #_____

Relationship to patient: Self Spouse Father Mother Domestic Partner

REQUIRES PCP REFERRAL: ***YES*** ***NO*** ***Insurance coverage***: **Medical** **Vision**

MEDICAL HISTORY:

Current medications:_____ or √ See List in Chart_____

Allergies (medications and/or others):_____

Family History: ◊ Glaucoma ◊Cataracts ◊ Macular Degeneration ◊ Diabetes ◊ High Blood Pressure ◊ Heart Disease ◊ Other- please list:_____

Please list all major illnesses including surgeries: _____

_____

Height_____ Weight_____

If you were referred into our office- who may we thank for your referral?_____

Patient Signature: *(guardian if minor)*_____***Date:***_____