

# Eye Clinic

1045 N. Courtenay Parkway  
Merritt Island, FL 32953

## PATIENT REGISTRATION

PATIENT INFORMATION

SIGNATURE

PATIENT NUMBER					
LAST NAME			FIRST NAME & MIDDLE INITIAL		
ADDRESS LINE 1					
ADDRESS LINE 2					
CITY		STATE	ZIP		HOME PHONE
DATE OF BIRTH	SEX	MARITAL STATUS (M/S)		REFERRED BY	
PATIENT S.S. NO.			ETHNIC ORIGIN: <i>Please Circle</i> Amer. Indian    Asian    Black		
PATIENT'S EMPLOYER			White    W Hispanic    B Hispanic    Other    No Response		
EMPLOYER ADDRESS					
CITY			STATE	ZIP	
EMPLOYER PHONE		EXT.			
RESPONSIBLE PARTY LAST NAME		FIRST NAME & INITIAL		RELATIONSHIP	
ADDRESS					
CITY		STATE	ZIP		PHONE
RESPONSIBLE PARTY DATE OF BIRTH		RESPONSIBLE PARTY S.S. NO.			
SPOUSE'S NAME				SPOUSE'S WORK PHONE	
NEAREST LIVING RELATIVE OR FRIEND NOT LIVING WITH YOU				RELATIVE/FRIEND PHONE	
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.					DATE
AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.					DATE

## INSURANCE INFORMATION