Tri-State Centers for Sight inc.

REGISTRATION FORM

PATIENT INFORMATION

Mr. ☐ Ms. ☐ Mrs. ☐ Sex: Male ☐ Female ☐

Patient Name _____ Date of Birth ____/____/____
Month / Date / Year

Social Security ___ — ___ — _____

Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Home Address _____

City _____ State _____ Zip _____ Phone (_____) _____

Cell Phone (_____) _____ Email Address: _____

Employer _____

Address _____

City _____ State _____ Zip _____ Phone (_____) _____

Circle ALL that are applicable for the patient: Full-time / Part-time / Not Employed / Self Employed / Retired
Active Duty / Full-time Student / Part-time Student / Not a Student

Family Physician _____ Referring Physician _____

Other Referral Source: Phone Book ☐ Friend ☐ Advertisement ☐

Other (describe) _____

Complete this section for either your Spouse or your Parent (if patient is a minor)

Name _____ Date of Birth ____/____/____
Month / Date / Year

Employer _____

Address _____

City _____ State _____ Zip _____ Phone (_____) _____

IN CASE OF EMERGENCY CALL

Name _____ Relationship _____ Phone (_____) _____

INSURANCE INFORMATION
Please complete the following for the subscriber of each insurance plan for which you have coverage.

Primary Insurance

Subscriber's Name _____ Relationship _____

Subscriber's Date of Birth ___/___/___ (Month / Date / Year) Subscriber's Social Security ___ ___ Sex M or F (Circle One)

Subscriber's Identification Number _____ Patient's Identification Number _____

Employer _____

Address of Employer _____

City _____ State _____ Zip _____ Phone (_____) _____

Secondary Insurance

Subscriber's Name _____ Relationship _____

Subscriber's Date of Birth ___/___/___ (Month / Date / Year) Subscriber's Social Security ___ ___ Sex M or F (Circle One)

Subscriber's Identification Number _____ Patient's Identification Number _____

Employer _____

Address of Employer _____

City _____ State _____ Zip _____ Phone (_____) _____

Third Insurance

Subscriber's Name _____ Relationship _____

Subscriber's Date of Birth ___/___/___ (Month / Date / Year) Subscriber's Social Security ___ ___ Sex M or F (Circle One)

Subscriber's Identification Number _____ Patient's Identification Number _____

Employer _____

Address of Employer _____

City _____ State _____ Zip _____ Phone (_____) _____

Work Related Injury
(complete this section if today's exam is related to an injury obtained while performing work related duties)

Date of Injury ___/___/___ (Month / Date / Year) Worker's Compensation Claim Number _____

Employer at time of injury _____

Employer's Phone (_____) _____ Contact Person _____