

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? _____

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> My optometrist | <input type="checkbox"/> News-Press | <input type="checkbox"/> Seminar |
| <input type="checkbox"/> My family physician | <input type="checkbox"/> Naples Daily News | <input type="checkbox"/> Web site |
| <input type="checkbox"/> Family/patient/friend | <input type="checkbox"/> Town paper | <input type="checkbox"/> Coupon/Mail |
| <input type="checkbox"/> Television | <input type="checkbox"/> Radio | <input type="checkbox"/> Yellow Pages |
| <input type="checkbox"/> My insurance plan | <input type="checkbox"/> Other _____ | |

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