WELCOME TO THE FAMILY EYE CARE CENTER
PATIENT REGISTRATION FORM

PATIENT INFORMATION DATE

LAST NAME	FIRST NAME	MI	NICK NAME	
PHYSICAL ADDRESS		CITY	ST	ZIP
MAILING ADDRESS		CITY	ST	ZIP
DOB	AGE	□ MALE □ FEMALE IDENTIFY AS		
SS#	LANGUAGE	RACE	MARITAL STATUS **M W S D**	
HOME ( ) -		CELL ( ) -	TEXT REMINDERS: **Y N**	
E-MAIL ADDRESS			E-MAIL REMINDERS **Y N**	
EMPLOYER		OCCUPATION	PHONE # ( ) -	
ADDRESS			EMPLOYMENT STATUS	
IS PATIENT CURRENTLY UNDER HOSPICE CARE? YES NO				

PARENT / GUARDIAN / INFORMATION (Authorized Representative)

NAME	RELATIONSHIP TO PATIENT
PHONE # ( ) -	ADDRESS
EMPLOYER	DOB

INSURANCE INFORMATION SUBSCRIBER OTHER THAN PATIENT (spouse, parent, guardian)

SUBSCRIBER NAME	DOB	
SUBSCRIBER EMPLOYER	RELATIONSHIP	
PRIMARY MEDICAL INS.	ADDRESS	
POLICY #	GROUP #	
SECONDARY MEDICAL INS.	ADDRESS	
POLICY #	GROUP #	
VISION INSURANCE	ADDRESS	
POLICY #	GROUP #	
EMERGENCY CONTACT		

NAME	RELATIONSHIP TO PATIENT
PHONE #	ADDRESS

NOTE: Most insurance policies pay only a portion of your total charges. If you have any questions about your coverage, please contact your representative. We do not guarantee the accuracy of benefit information given to us by insurance companies. Please understand that **financial responsibility for your account is yours, not the responsibility of your insurance company**. I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical or vision benefits either to the physician or supplier of the service rendered or to myself if the provider does not accept assignment. **I understand that I am responsible for any balance my insurance does not pay.** _____ Initials

PAYMENT IS EXPECTED ON DATE OF SERVICE

_____CASH _____CHECK _____CREDIT CARD _____FECC VISION DIRECT
(i.e., CO-PAYS, DEDUCTIBLES, CO-INSURANCE, GLASSES, CONTACT LENSES, ETC.)

SIGNATURE X_____ DATE_____
Form updated 11-21