

# ASSOCIATED EYECARE REGISTRATION FORM

Due to provisions of the Health Care Act of 2010 and other regulations, we are required to collect certain personal, race, ethnic, language, and health related information. All personal information is confidential and protected. Please provide all requested information.

<b>Today's date:</b>			<b>Your Medical Doctor:</b>			
<b>Patient's Last Name:</b>		<b>First:</b>	<b>Middle:</b>	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	<b>Preferred Method of Contact:</b>
				<input type="checkbox"/> home <input type="checkbox"/> cell(txt) <input type="checkbox"/> email		
<b>Home phone:</b> (   )	<b>Work phone:</b> (   )	<b>Cell phone:</b> (   )	<b>Carrier</b>	<b>Birth date:</b> / /	<b>Sex:</b> <input type="checkbox"/> M <input type="checkbox"/> F	
<b>Street address:</b>			<b>Social Security #:</b>		<b>Email:</b>	
<b>P.O. box:</b>	<b>City:</b>		<b>State:</b>	<b>ZIP Code:</b>		
<b>Responsible party(if minor):</b>			<b>Your Occupation:</b>			
<b>Address(if different):</b>			<b>Phone(if different):</b>			
<b>Race:(select one)</b> <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> white <input type="checkbox"/> other <input type="checkbox"/> decline to answer			<b>Ethnicity:</b> <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> decline to answer			
<b>Preferred Language:</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other		<b>Special Needs:</b> <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Translator <input type="checkbox"/> Wheelchair		<b>Mother's maiden name:</b> <b>Mother's Birth State:</b>		

## INSURANCE INFORMATION

<b>Primary Insurance:</b>	<b>Employer:</b>	<b>Employer address:</b>	<b>Employer phone#:</b> (   )
<b>Subscriber's name:</b>	<b>Birth date:</b> / /		
<b>Patient's relationship to subscriber:</b>	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		
<b>Secondary insurance (if applicable):</b>	<b>Subscriber's name:</b>		
<b>Patient's relationship to subscriber:</b>	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		

## VISION INSURANCE

<b>Name of Insurance:</b>	<b>Policy #:</b>	<b>Group#(if applicable):</b>		
<b>Subscriber name:</b>	<b>Subscriber's SS#</b> (last 4 #'s)	<b>Subscriber's DOB:</b>	<b>Employer:</b>	<b>Relationship to Subscriber:</b>

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Associated Eyecare or insurance company to release any information required to process my claims.

Patient/Guardian Signature	date
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