

Pelham Parkway Vision Center REGISTRATION FORM

(Please Print)

Today's Date ____/____/____

PCP _____

PATIENT INFORMATION

Patient's Last Name		First	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid	
Full time student? <input type="checkbox"/> Yes <input type="checkbox"/> No	Social Security		Alternative Phone		Birth Date / /		Age Sex <input type="checkbox"/> M <input type="checkbox"/> F
Street Address		Apt.#	City	State	ZIP Code	Home Phone No. ()	
Occupation			Employer			Employer Phone No. ()	
Referred to Vista Site Eye care by				<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan		<input type="checkbox"/> Hospital
<input type="checkbox"/> Family		<input type="checkbox"/> Friend		<input type="checkbox"/> Yellow Pages		<input type="checkbox"/> Other	

Name and Telephone of Primary Care Physician

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Is this patient covered by insurance? Yes No

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	ID#	Co-Payment \$
Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child					
Name of Secondary Insurance (if applicable)		Subscriber's Name		Group #	Policy #
Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No. ()	Work Phone No. ()
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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 **VISTASITE EYECARE** or insurance company to release any information required to process my claims.

X _____
PATIENT/GUARDIAN SIGNATURE DATE