

PACIFIC VISION MEDICAL CENTER

Registration Form

Mr Mrs Miss or Ms

Patient Name: _____ SS # _____
Last First Middle

Date of Birth: _____ Sex: F M Marital Status: Single Married Other

Race: American Indian or Alaska Native Ethnicity: Hispanic or Latino/Latina
 Native Hawaiian or Pacific Islander Non-Hispanic or Non-Latino
 Black, or African American Decline
 White Asian Decline Preferred Language: _____

Mailing Address: _____

Residence Address: _____

Phone Numbers: Home _____ Work _____ E-Mail _____

Your primary medical doctor name: _____

Your occupation: _____ Employer name: _____

Please tell us how you found out about us: Physician referred, name: _____
 Friend, name: _____ Website Phone book Health Plan list of Doctors
 Newspaper ad Radio ad Our office sign OTHER: _____

Spouse name: _____ Spouse employer phone: _____

Spouse employer name: _____

Nearest relative name: _____ Relative phone: _____

If patient is a minor, responsible party name(s): _____

Primary insurance: _____
Subscriber name: _____
Subscriber DOB: _____
I.D.# _____ Group # _____
Address: _____
City/ST/Zip: _____
Phone # _____

Secondary Insurance: _____
Subscriber name: _____
Subscriber DOB: _____
I.D.# _____ Group # _____
Address: _____
City/ST/Zip: _____
Phone # _____

Vision Insurance:
Vision Insurance Plan: _____
Address: _____
City/ST/Zip: _____

Subscriber name: _____
Subscriber DOB: _____
Subscriber ID#: _____ Group #: _____

I authorize Pacific Vision Medical Center to use and/or disclose my health and financial information to the person(s) listed below:
Spouse _____ Children: _____ Other: _____
It is okay to leave a message on my phone Yes No