Pacific Vision Medical Center
515 East Washington Blvd., Crescent City, CA 95531 | Tel: (707) 465-2020
580 5th Street, Suite 500, Brookings, OR 97415 | Tel: (541) 469-5800

PATIENT REGISTRATION FORM

PATIENT INFORMATION

□ **Mr.** □ **Mrs.** □ **Miss** □ **Ms.** **SSN #:** _____ **Today's Date:** _____

Patient Name: (Last) _____ (First) _____ (MI) __ **Preferred Name:** _____

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

Home Phone #: _____	**Cell Phone #:** _____	**Work Phone #:** _____
□ Okay to leave msg	□ Okay to leave msg	□ Okay to leave msg

Mailing Address: _____ **E-mail Address:** _____

Residence Address: _____ **Preferred Language:** _____

Occupation: _____ **Employer:** _____

Race: □ White □ American Indian or Alaska Native □ Native Hawaiian or Pacific Islander □ Asian □ Black, or African American □ Decline to answer

Ethnicity: □ Non-Hispanic or Non-Latino □ Hispanic or Latino □ Decline to answer

Primary Medical Doctor Name: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact: _____ **Relationship to Patient:** _____ **Phone #:** _____

Spouse's Name: _____ **Spouse's Employer:** _____ **Phone #:** _____

Nearest Relative: _____ **Relative's Phone #:** _____

AUTHORIZATION

I authorize Pacific Vision Medical Center to use and/or disclose my health and financial information to the person(s) listed below: This authorization will remain in effect until you instruct otherwise

□ **Spouse – Name:** _____ □ **Other – Name(s):** _____

□ **Child(ren) – Name(s):** _____ □ **Allow Access to my Patient Portal**

HOW DID YOU HEAR ABOUT US?

□ **Physician Referred – Name:** _____ □ **Friend – Name:** _____ □ **Other:** _____

□ **Phone Book** □ **Radio Ad** □ **Newspaper Ad** □ **Our Office Sign** □ **Health Plan List of Doctors** □ **Website**

INSURANCE INFORMATION

Primary Insurance: _____
Subscriber Name: _____ DOB: _____
I.D. #: _____ Group #: _____
Address: _____
City / State / Zip: _____
Phone #: _____

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

Vision Insurance Plan: _____
Subscriber Name: _____ DOB: _____
I.D. #:_____ Group #: _____
Address: _____
City/State/Zip: _____ ***If Patient is a minor, responsible party name(s):** _____