Polsinelli Optometry

REGISTRATION FORM

(Please Print)

Today's date: / /	PCP:

PATIENT INFORMATION

Patient's last name:	First:	MI:	❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	I Prefer to be called:	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

City:	State:	ZIP Code:	Cell phone no.: ( )

Occupation:	Employer:	Employer phone no.: ( )

Email Address:	Preferred form of communication: ❑ Cell ❑ Home ❑ Work ❑ Email

Whom may we thank for referring you?	❑ Dr.	❑ Hospital:

❑ Family:	❑ Friend:	❑ Close to home/work	❑ Yelp	❑ Insurance Plan	❑ Other:

ACCOUNT RESPONSIBLE

Person responsible for bill: ❑ Same as above – skip to insurance information section

Name:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here?	❑ Yes ❑ No	Relationship to patient: ❑ Spouse ❑ Parent ❑ Other:

Employer:	Employer address:	Employer phone no.: ( )

INSURANCE INFORMATION

Is patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ VSP	❑ United Healthcare	❑ Cigna	❑ BC/BS	❑ Medicare	❑ Other:

Name of Insured:	Insured's S.S. no.:	Birth date: / /	Group no.:	ID no.:

Patient's relationship to insured:	❑ Self	❑ Spouse	❑ Child	❑ Other:

Name of secondary insurance (if applicable):	Insured's name:	Group no.:	ID no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other:

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home/cell phone no.: ( )	Work phone no.: ( )

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

PATIENT/GUARDIAN SIGNATURE **DATE**