PATIENT REGISTRATION FORM:

Please Print And Fill Out Completely

| Name: Mr. Mrs. Miss Ms | First | Middle | Li | ast |
|--|--|--|---|---|
| Date of Birth: | Social Security No.: | | | Male/Female |
| Local Address: | | | | |
| Street | Cit | .y | State | Zip |
| Local Phone: Home | Work | | Cell | |
| Spouse's Name: | Email Add | lress: | | |
| Out of Area Address:Stre | | | | |
| Stre | eet | City | State | Zip |
| Out of Area Phone: Home | | | _ | |
| Contact Person (not living with you | ı): | | | |
| Relationship: | PI | none No.: | | |
| Primary Care Physician: Patient's Rights of Disclosures restriction on uses and disclosures confidential communications of he list all persons in your household may speak regarding your medical | In general, the HIPAA of health information. Talth information be made | privacy rule g he individual by alternativ | ives the individu is also provided e means. | al the right to re the right to requ |
| Insurance Lifetime Authorizat Stephenson Eye Associates. I auth determine these benefits of service Fee Consent: I understand that that I am financially responsible for for all charges. | norize medical information es if necessary. not all services performed | n be released d may be cov | to the insurance ered by my insur | e company to rance. I unders |
| Patient's Signature: | | | Date: | |
| Parent or Guardian Signature: | | | Date: | |