THE CENTER FOR CORRECTIVE EYE SURGERY, LLC

Registration Form

Today' Date _____/_____/_____ Physician_____

PATIENT INFORMATION

Patient Last Name: _____ First _____Middle Initial_____
Marital Status_____ Birth Date _____/_____/_____ Phone: (home)_____
(cell) _____ SS#_____

Street Address: _____, City _____, State_____,

Zip Code: _____ Occupation: _____

Employer: _____ Emp Phone: _____

Primary Care Physician: _____, Primary Care Physician Phone: _____

How did you learn about our practice? _____

INSURANCE INFORMATION

Email Address: _____

Subscribers Name: _____ Date of Birth: ____/_____/_____
Address (If different then patient) _____, City_____,
State: _____, Zip Code: _____Name of Insurance: _____,
ID#_____, Group #_____
Patient's relationship to Subscriber: Self ☐ Spouse ☐ Child ☐ Other ☐_____
Secondary Insurance: _____, ID#_____,
Group#_____Patient's relationship to Subscriber: Self ☐ Spouse ☐ Child ☐ Other ☐

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living in same address) _____
Phone:_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand I am financially responsible for any balance. I also authorize The Center for Corrective Eye Surgery, LLC or insurance company to release any information required to process my claims.

X _____
Patient/Guardian Signature

Date: _____