Patient Registration

East Valley Ophthalmology, Ltd.

Name: _____ Today's Date: _____
Last First MI Month / Day / Year

Address: _____
Street City State Zip

Summer Address: _____
Street City State Zip

Home Phone: _____ Work Phone: _____ Social Security Number: _____

Age: _____ Date of Birth: _____ Male ____ Female ____ Marital Status: S M W D
Month / Day / Year

Employed By: _____ Retired _____ Occupation: _____

Address: _____ Telephone: _____

Spouse or Parent's Name: _____

Relative not living with you: _____ Relationship: _____

Address: _____ Telephone: _____

Different person responsible for payment? _____ Relationship: _____

Address: _____ Telephone: _____

Date of Birth: _____ Social Security Number: _____

If you are married, what is the date of birth of your spouse? _____

What is the name of your primary care physician? _____ M.D. D.O.

How did you hear about our office? Yellow Pages Friend Family Member Hospital Health Plan Directory

Another patient, who? _____ Another doctor, who? _____

Health Insurance Information

Do you have health insurance? Yes No Medicare? Yes No **Your Medicare Number**: _____

If not Medicare, what is the name of your primary medical insurance? _____

Non-Medicare primary insurance policy holder's name: _____
Last First MI

Do you have secondary medical insurance? Yes No Secondary Insurance Name: _____

For billing purposes, our receptionist may wish to make a copy of your insurance plan cards.