Oneonta Eye & Laser Center

PATIENT REGISTRATION
PLEASE PRINT

TODAY'S DATE:_____/_____/_____

PATIENT NAME: _____
(FIRST, MIDDLE, LAST)

DATE OF BIRTH: _____/____/_____ AGE:_____

ADDRESS:_____

SEX:_____MARITAL STATUS: _____

CITY:_____STATE:_____ZIP:_____

PERSONAL PHYSICIAN: _____

TELEPHONE #: ( ) _____

REFERRED HERE BY DR.: _____

ALTERNATIVE #: ( ) _____

DR. ADDRESS: _____

CELL PHONE #: ( )_____

CITY:_____ STATE: _____ ZIP:_____

SOCIAL SECURITY #:_____

EMPLOYER: _____

RESPONSIBLE PARTY: _____
(FOR PERSONS UNDER 18 YEARS OF AGE)

ADDRESS: _____

CITY:_____ STATE: _____ ZIP:_____

ADDRESS:_____

TELEPHONE #: ( )_____

CITY:_____STATE:_____ZIP:_____

OCCUPATION: _____

TELEPHONE #: ( ) _____

IS TODAY'S VISIT RELATED TO AN ACCIDENT?

SOCIAL SECURITY #:_____

☐ WORK ☐ AUTO ☐ OTHER_____

RELATIONSHIP TO PATIENT: _____

PHARMACY: _____ PHARMACY ADDRESS: _____

REASON FOR TODAY'S VISIT: _____

MEDICAL HEALTH INSURANCE INFORMATION:

PRIMARY COVERAGE: _____

NAME OF INSURED: _____

POLICY #: _____

GROUP #: _____

SECONDARY COVERAGE: _____

NAME OF INSURED: _____

POLICY #: _____

GROUP #: _____

ADDITIONAL COVERAGE: _____

NAME OF INSURED: _____

POLICY #: _____

GROUP #: _____

I request that payment of authorized Medicare and/or other type of insurance benefits be made either to me or on my behalf to Oneonta Eye and Laser Center for any service furnished to me by that physician. I authorize any holder of medical information about me to be released to the Health Care Financing Administration, its agents, and any other registered insurance company, any information needed to determine these benefits or the benefits payable to related services.

Signature of Beneficiary:_____
(Person receiving the benefits at this time.)