Anna Eyecare, PA

REGISTRATION FORM

(Please Print)

Today's Date:		Primary Care Physician:			
PATIENT INFORMATION					
Patients Last Name: First: Middle:			Circle: Mr. Mrs. Miss Ms.		Marital Status: Single Mar Div Sep Wid
Is this your legal name? Yes No	If not, what is your legal name?	(Former Name):	Birth Date:	Age:	Sex: ☐Male ☐Female
Street Address:		Social Security Number:		Home Phone: ( )	
City:	State:	Zip:		Cell Phone: ( )	
Occupation:	Employer:		Employer Phone #: ( )		
How Did You Hear About Our Office? ☐ Insurance Plan ☐ Family ☐ Friend ☐ Close to Home/Work ☐ Online ☐ Phone Book ☐ Flyer ☐ Other_____					
Other Family Members Seen Here:					
Name of Parent or Spouse:					

INSURANCE INFORMATION			
(Please give your insurance card to the receptionist)			
Name of Insurance:		Policy Number:	
Subscriber's Name:	Subscriber's SS #:	Birth Date:	Group #:
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____			
Name of Supplemental Insurance:		Policy Number:	
Subscriber's Name:	Subscriber's SS #:	Birth Date:	Group #:
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other_____			

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to Patient:	Home Phone: ( )	Work 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 that I am financially responsible for any balance. I also authorize Christopher R. Jackman, O.D. or insurance company to release any information required to process my claims. X_____ _____ *Patient/Guardian Signature* *Date*			