PAJKA EYE CENTER • PATIENT REGISTRATION SHEET

Mr. Mrs.
Miss Ms. _____ Sex ☐ Male ☐ Female

Address _____ City _____ St _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____ Add'l Phone (Son, Dau., etc.) _____

Social Security No. _____ Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Date of Birth _____ Age _____ Emergency Contact Person _____ Phone _____

Employer's Name _____ Occupation _____

Employer's Address _____ Phone _____

Responsible Party ☐ Self ☐ Spouse or Other

If Other: Name _____ Social Security Number _____

Relationship to patient (Father, Mother, Spouse, etc.) _____

Address _____ Phone _____

Employer _____

Employer Address _____ Employer Phone _____

INSURANCE INFORMATION

Do you have Insurance? ☐ Yes ☐ No If not, how do you intend to pay for this visit? ☐ Cash ☐ Check ☐ Credit Card

Do you have a Co-Pay? ☐ Yes ☐ No Amount of Co-Pay _____

If you have insurance, please bring your cards with you, we will ask to copy them the day of your appointment. If your insurance requires a referral from your family doctor (PCP), please obtain that prior to your visit.

Primary Insurance _____ Who is the Subscriber? _____

Secondary Insurance _____ Who is the Subscriber? _____

If Subscriber is other than patient, please give:
Date of Birth _____ Social Security Number _____

Who is your Optometrist? _____ Did they provide your Glasses / Contacts? ☐ Yes ☐ No

Who is your Family Doctor (PCP)? _____

Pharmacy Name _____ Pharmacy Address _____

How did you hear about us? ☐ Optometrist ☐ Family Doctor ☐ Friend ☐ Relative ☐ Phone Book ☐ Newspaper Ad/Story
☐ Television ☐ Screening ☐ Radio ☐ Direct Mail ☐ Other _____

Whom may we thank for referring you? _____

Address _____ City _____ St _____ Zip _____

May we send a thank you not for the referral? ☐ Yes ☐ No

I hereby assign, transfer, and set over to Pajka Eye Center all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine those benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Signature _____ Date _____