PAJKA EYE CENTER • PATIENT REGISTRATION SHEET

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

Address _____ City _____ St _____ Zip _____

Primary Phone _____ Secondary Phone _____ Work Phone _____ Email _____

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 _____ Co-pays, deductibles and co-insurances are expected to be paid at the time of service.

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 _____

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 _____