EYE CARE FOR TULSA, INC

Patient Registration

Patient Info

Name _____ DOB _____ Sex M / F
Last First MI

Address _____ City _____ State _____ Zip _____

Home PH _____ Cell PH _____ Work PH _____

SSN _____ - ___ - _____ Marital Status _____ E-mail _____

Race (Please check all that apply)

__ American Indian or Alaskan Native
__ Black / African American
__ Caucasian
__ Hispanic Origin
__ Asian
__ Native Hawaiian or Pacific Islander
__ Other
__ Not Hispanic Origin

Primary Care Physician _____ Phone _____

Account Responsible *(Complete only if different from patient)*

Name _____ DOB _____ Sex M / F
Last First MI

Relationship to Patient _____ SSN _____ - ___ - _____

Address _____ City _____ State _____ Zip _____

Home PH _____ Cell PH _____ Work PH _____

E-mail _____

Emergency Contacts

Name _____ Phone _____
Name _____ Phone _____
Name _____ Phone _____

Insurance *(Please provide copies of all insurance cards)*

Primary Medical _____ ID # _____ Group # _____
Secondary Medical _____ ID # _____ Group # _____
Vision Insurance _____ ID # _____ Group # _____
Patient's relationship to Insured Member __ Self __ Spouse __ Child __ Other

_____

_____ _____

Signature of Patient (Parent/Guardian if minor) **Date**