Registration Form

Name: First _____ MI _____ Last _____ DOB: _____
Address: _____ City: _____
State:_____ Zip: _____ Home Phone: ( ) _____ Cell Phone: ( ) _____
Gender: ❑Male ❑Female Marital Status: ❑Single ❑Married ❑Widowed ❑Separated ❑Divorced
Patient's Occupation: _____ Employer: _____
Employer Address: _____ City: _____
State:_____ Zip: _____ Employer Phone: ( ) _____ Soc. Sec #: _____
CDL: _____ Email address:_____ Referred by: _____
Ethnicity:_____ Language: _____ Race: _____
Preferred Method for Receiving Confidential Communication: ❑Cell Phone ❑Home Phone ❑E-Mail ❑Mail

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Payment Method: ❑Cash ❑Medicare ❑Medi-Cal ❑HMO ❑Insurance ❑Other _____
Insurance Name: _____Policy ID No.: _____Group No.: _____

Complete this section if responsible party is someone other than the patient.
Name of Resp. Party: First _____ Middle _____ Last _____
Relationship of patient to insured: ❑ Child ❑ Spouse ❑ Dependent ❑ Other _____
Address: _____ City: _____ State: _____ Zip: _____
Responsible Party Occupation:_____ Employer: _____
Employer Address: _____ City: _____
State:_____ Zip: _____ Employer Phone: ( ) _____ Soc Sec #: _____

Complete this section if there is a secondary insurance: ❑ AARP ❑ Blue Cross ❑ Other _____
Insurance Name: _____Policy ID No.: _____Group No.: _____

Person at different address & telephone number to be notified in case of emergency, **<Do Not Leave Blank>**
Name: _____ Address/City: _____
State_____ Zip: _____ Phone: ( ) _____ Relationship: _____

I hereby authorize Soledad Eye Surgeons Medical Group to furnish to insurance carriers information concerning this illness/accident, and hereby irrevocably assign to the physician all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. A copy of this authorization shall be considered as valid as the original.

Signature: _____ Date:_____
Signed by: ❑ Self ❑ Parent ❑ Spouse ❑ Other _____
❑ Legal Guardian (must provide documentation) - Name: _____