SEATTLE VISION CARE CENTER

Patient Registration Form

Today's Date _____

Chart # _____

PATIENT INFORMATION

Last Name	First Name	Middle Name

Gender	Marital Status	DOB	SSN

Patient's Address	City	State	Zip

Home Phone	Day Phone	Cell Number

Occupation	Employer	How Did You Hear About Us?

Preferred Pharmacy	Pharmacy Cross-streets	Pharmacy Phone Number

How May We Contact You? (Please Select All That Apply) Mail ☐ Text ☐ Phone ☐ Email ☐

Email Address

Please indicate if is okay for us to leave a confidential voicemail that may include test results, prescription information, or any other medical information pertaining to your health. This will reduce the need for you to return our call if you have any additional questions. This should be a phone number where only you, or anyone you are comfortable with hearing your medical information, has access to.

Phone number that is ok to leave message on	Initials

PRIMARY VISION INSURANCE

Insurance Company Name	ID#	Group #

Street Address	City, State, Zip	Phone #

Subscriber Information (Policy Holder) (MUST have ALL fields complete to bill insurance)

☐ SAME AS PATIENT

Last Name	First Name	Middle Name

Gender	Marital Status	DOB	SSN

Address	City	State	Zip

Home Phone	Cell Phone	Work Number

Occupation	Employer	Relationship to Subscriber (Policy Holder)

Parent / Guardian / Spouse / Domestic Partner

Last Name	First Name	Middle Name

Gender	Marital Status	DOB	SSN

Address	City	State	Zip

Home Phone	Cell Phone	Work Number	Ok to call at work?

Occupation	Employer	Relationship to Patient

I have provided accurate information regarding my identity, insurance information and health history to the best of my knowledge and ability. I have read and understood the office policies and my HIPAA right as stated in the notification provided. I accept full responsibility for payment of all goods ordered and services rendered in this office. I understand that all purchases are final.

Signature _____ Date _____ STAFF INITIALS