THE EYE CLINIC NJ

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ M.I._____ Date of Birth: _____

Sexual Identity: _____ Social Security #: _____If Minor: Responsible Party: _____

Address: _____City: _____ST _____ZIP_____

Cell Phone: ( ) _____ Secondary Phone: ☐ Home / ☐ Work ( ) _____

Email: _____ Marital Status: M S D W Employer:_____

Emergency Contact/HIPPA: _____ Telephone: _____

HOW DID YOU HEAR ABOUT US

Website	☐	Facebook	☐
Google/Yahoo/Bing	☐	Friend or Family_____	☐
Newspaper/Magazine Ad	☐	Other (e.g., CVS) _____	☐

ISURANCE INFORMATION

Primary Insurance: _____ **Secondary Insurance:** _____

Policy/ID #: _____ Policy/ID#_____

Group/Plan #: _____ Group/Plan #: _____

Policyholder Name: _____ Policyholder Name: _____

D.O.B.: _____ D.O.B.: _____

S.S.# _____ S.S.#: _____

DEMOGRAPHIC INFORMATION REQUEST

Race		Ethnicity
☐ American Indian or Alaska Native	☐ Native Hawaiian or Other Pacific Islander	☐ Hispanic or Latino
☐ White	☐ Black or African American	☐ Not Hispanic or Latino
☐ Asian	☐ Patient Declined	☐ Patient Declined

DESIGNATED DISCLOSURE AUTHORIZATION /HIPPA

I allow The Eye Clinic NJ to disclose medical information as needed to the following designated individual(s) involved with my health care. I understand that I am not required to list anyone. I also understand that I may change the list in writing any time.

_____	_____	_____	_____
Print Name	Date of Birth	Relationship	Phone Number

PHARMACY/ PRIMARY/ REFERRING DOCTOR INFORMATION **** must be filled out****

PHARMACY NAME: _____ **PHONE:** (_____)_____

PRIMARY DOCTOR: _____ **ADDRES:** _____**PHONE:** _____

REFERRING DOCTOR: _____ **ADDRESS:** _____**PHONE**: _____

SIGNATURE: _____ **DATE:** _____