PROGRESSIVE EYECARE & EYEWEAR

REGISTRATION FORM

(Please Print)

Today's Date:	Account Number:

PATIENT INFORMATION

Patient's Last Name:	First (legal):	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital Status (circle one) Single / Mar / Div / Sep / Wid

Preferred Name/Nickname:	Former Name:	Last Four SSN:	Birth Date: / /	Age:	Sex: ❑ M ❑ F

Race:	Ethnicity: ❑ Hispanic ❑ Not Hispanic	Primary Language:	Occupation/Employer:

Street Address:	City:	State:	ZIP Code:

E-mail:	Cell Phone: ( )	Home phone: ( )

Referred by: (please check one box):

❑ Insurance Plan: _____ ❑ Dr: _____ ❑ Internet site: _____

❑ Family Member: _____ ❑ Friend: _____ ❑ Close to Home/Work

Other family members seen here:

ACCOUNT RESPONSIBLE (IF DIFFERENT)

(Please give your insurance card to the receptionist.)

Person Responsible for Bill:	Birth Date: / /	Address (if different):	Home Phone No.: ( )

Is this person a patient here? ❑ Yes ❑ No

Vision insurance: ❑ VSP ❑ Eyemed ❑ VCP ❑ Wellness Plan (through Medical)

Subscriber's Name: Social Security Number: Birth Date: / /

Medical Insurance

Name of Primary Insurance:	Subscriber's Name:	Birth Date: / /	Group No.:	Policy No.:	Co-payment: $

Patient's Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of Secondary Insurance (if applicable):	Subscriber's Name:	Group No.:	Policy No.:

Patient's Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to Patient:	Home Phone No.: ( )	Work Phone No.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Progressive eyecare & eyewear or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*