st. paul eye clinic P.A.

Registration Information

Please Print

(Office Use Only)

RP Number _____ Patient ID # _____ Receptionist _____

Dr. _____ Appointment Date _____

PATIENT INFORMATION

Have you or any member of your family ever been seen by a St. Paul Eye Clinic doctor before? ❑ **Yes** ❑ **No**

Name _____ Birthdate _____
(LAST) (FIRST) (MIDDLE INITIAL)

Sex _____ Marital Status _____ Employer _____ Occupation _____

Apt. No. _____ Street Address _____

City _____ State _____ Zip _____ Email Address _____

Home Telephone _____ Work Telephone _____ Cell Telephone _____

Emergency Contact _____ Phone _____ Relationship _____

Primary Care Doctor _____ Clinic _____

Name of person(s) authorized to request information regarding my medical care and treatment:

_____ Relationship _____

_____ Relationship _____

Referred by (Doctor) _____ Address _____

PARTY RESPONSIBLE FOR ACCOUNT PAYMENT (If other than patient)

Name _____ Relationship to Patient _____

Apt. No. _____ Street Address _____

City _____ State _____ Zip _____

Home Telephone _____ Work Telephone _____ Cell Telephone _____

Email address

INSURANCE INFORMATION

Please present insurance card to receptionist

PRIMARY INSURANCE COMPANY NAME _____

Group Number _____ Identification Number _____

Policy Holder Information:

Name _____ Sex _____ Birthdate _____
(LAST) (FIRST) (MIDDLE INITIAL)

Social Security # _____ – _____ – _____ Employer _____ Work Telephone _____

Apt. No. _____ Street Address _____

City _____ State _____ Zip _____

SECONDARY INSURANCE COMPANY NAME _____

Group Number _____ Identification Number

Policy Holder Information:

Name _____ Sex _____ Birthdate _____
(LAST) (FIRST) (MIDDLE INITIAL)

Social Security # _____ – _____ – _____ Employer _____ Work Telephone _____

Apt. No. _____ Street Address _____

City _____ State _____ Zip _____