



**Verdier  
Eye  
Center**

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**VerdierEyeCenter.com**

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## PATIENT REGISTRATION FORM

### PATIENT INFORMATION

Mr. /  Ms. /  Mrs. /  Miss /  Dr. \_\_\_\_\_  
First Name Middle Initial Last Name

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Race: \_\_\_\_\_ Ethnicity:  Decline to Specify /  Hispanic/Latino /  Not Hispanic/Latino Sex: \_\_\_\_\_

Preferred Language: \_\_\_\_\_ Email Address: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Married (Spouse's Name: \_\_\_\_\_) /  Divorced /  Single /  Widowed /  Other

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Optometrist/Ophthalmologist: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### IN CASE OF EMERGENCY CONTACT

Name: \_\_\_\_\_ Contact Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

### INSURANCE INFORMATION

#### Primary Insurance

Insurance Name: \_\_\_\_\_

Insurance ID #: \_\_\_\_\_

Group #: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_

Policy Holder Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

#### Secondary Insurance

Insurance Name: \_\_\_\_\_

Insurance ID #: \_\_\_\_\_

Group #: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_

Policy Holder Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

### PERSON RESPONSIBLE FOR ACCOUNT (IF DIFFERENT FROM PATIENT)

Full Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Sex: \_\_\_\_\_  
First Name Middle Initial Last Name

Social Security #: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

*The Patient or Guarantor is responsible for payment in full of all services rendered by the physicians or employees of Verdier Eye Center, PLC. Payment in full is expected at the time of service unless arrangements are made in advance or we have a contract to participate with your insurance carrier.*

#### AUTHORIZATION, ASSIGNMENT, AND RESPONSIBILITY OF ACCOUNT

*I hereby authorize Verdier Eye Center, PLC to release to the above insurance companies and/or their intermediaries and/or carriers any medical information needed for claims reimbursement. I hereby acknowledge and accept responsibility for payment in full of all services rendered to me by Verdier Eye Center, PLC.*

Patient/ Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_