

CARTY EYE ASSOCIATES, LTD.
PATIENT REGISTRATION

Last name: _____ First Name: _____ Mid init: _____
Please circle: Mr. Mrs. Ms. Miss MD PhD Jr. Sr. Other: _____
Street: _____ Apt # _____
City: _____ ST: _____ Zip: _____
Phone: Home: _____ Work: _____ Cell: _____
Email address: _____
Social Security #: _____ - _____ - _____ Sex: M F Marital status: S M W D
Employment Status: FT PT none Date of birth: ____/____/_____
Reason for visit: _____
Related to injury at work: Y or N Motor vehicle Accident: Y or N
Do you currently reside in a Skilled Nursing Facility? Y or N Hospice? Y or N
Referred to office by: _____
Family Doctor name and address: _____

Person responsible for medical bills incurred: Self Spouse Parent Other
Last Name: _____ First Name: _____ Mid init: _____
Street: _____ City: _____ ST: _____ Zip: _____
Phone; Home: _____ Work: _____ Cell: _____
Emergency contact: Name: _____ Phone: _____

EMPLOYMENT INFORMATION:

Patient's employer: _____ Job Title: _____
Employer's address: _____
Work phone: _____

PRIMARY INSURANCE INFORMATION:

Insurance company name: _____
Insured Name: _____ Insured SSN# ____/____/_____
Insured DOB: ____/____/____ Relationship to insured: Self Spouse Child other
Referral required? Y or N

SECONDARY INSURANCE INFORMATION:

Insurance company name: _____
Insured Name: _____ Insured SSN# ____/____/_____
Insured DOB: ____/____/____ Relationship to insured: Self Spouse Child other
Referral required? Y or N

VISION PLAN?

I hereby authorize payment to Carty Eye Associates, Ltd. of my insurance benefits otherwise payable to me but not to exceed the balance due to Carty Eye Associates, Ltd., regular charges for this period of treatment. I understand that I am financially responsible to Carty Eye Associates, Ltd. for the charges not covered by my insurance company.

Patient signature: _____ Date: _____
(Guardian or POA if patient a minor or unable to sign)