PATIENT REGISTRATION FORM

Today's Date: ________________

Patient information

Last name : ________________________ **First name:** _______________________ **Middle name:** __________________

Address: ____

Street/PO Box City State Zip

Home Phone: (   ) __________ **Cell:** (   ) ___________ **Email:** ____________________________________

Marital Status: Single / Married / Divorced / Widowed / Other

Birth Date: __________________ **Sex:** M / F **SS#:** ____

Language: __________________ **Race:** _______________________ **Ethnicity:** Hispanic or Latino / Non-Hispanic or Latino

Contact information

In addition to myself, I designate the following individual(s) as **my personal representative/emergency contact** and grant associates of Monson Vision permission to disclose (written or verbal) my protected health information to the individual(s) named below.

____

Name of representative/Responsible Party   Relationship to patient   Contact phone #

____

Name of representative/Responsible Party   Relationship to patient   Contact phone #

- Do we have permission to leave appointment information on your answering machine or with family members? **YES / NO**
- Do we have permission to leave test results/surgery information on your answering machine/with family members? **YES / NO**

☐ I choose not to designate any other person as my personal representative. I understand that I may revoke this authorization by written notice at any time.

Insurance Information – Must bring insurance card(s), we will take a copy at the front desk.

Primary Insurance Co.: ____________________________

Name of Policy Holder: ____________________________

Policy Holder's DOB: ____________________________

ID#: ____

Group Number: __________________________________

Employer: ______________________________________

Second Insurance Co.: ____________________________

Name of Policy Holder: ____________________________

Policy Holder's DOB: ____________________________

ID#: ____

Group Number: __________________________________

Employer: ______________________________________

Vision insurance: ☐ **VSP** ☐ **EyeMed** ☐ **Spectera** ☐ **Opticare** ☐ **Blue Vision** ☐ **Other** ___________ ☐ **None**

How did you hear about us?

Did a physician refer you? YES / NO   If yes, physician's name: ____

☐ MonsonVision.com ☐ Facebook ☐ Cache Valley Direct Savings-Guide

☐ Instagram ☐ Phonebook ☐ Radio ☐ Insurance ☐ Other: ____

☐ Friends/family _________________________

May we use your name in thanking this person? YES / NO

Signature of Patient / Responsible Party: ____

Responsible Party Name (if not the patient): ___________________________ Responsible Party DOB: _________________________

Relationship: __________________________________ SS#: ____

Thank you for filling out your patient information!