Independent Board Certified Practices of

RALEIGH

OPHTHALMOLOGY

Patient Registration

Date: ____________________

Patient's Name ______________________ **DOB:** __________ **Sex** M F **Status** S M W D

Home Address ______________________ **E-mail address** ______________________

City ____________ **State** ______ **Zip Code** ________ **SSN#** ____________

Phone (H) ____________ **Phone (W)** ____________ **Phone (Cell)** ____________

Billing address (if different) ______________________

City ____________ State ______ Zip Code ________

Emergency Contact ____________ **Relationship** ________ **Phone** ________

Patient Employer ____________ **Work Address** ______________________

Spouse's name ____________ DOB: ________ Employer ____________

Referring Physician ______________________ **Treating Physician(s)** ____________

Parent /Guardian/Responsible Party Information (If Minor)

Name ______________________ SSN ____________ DOB: ________

Address ______________________

Phone (H) ____________ Phone (W) ____________ Phone (Cell) ____________

Employer ______________________

Insurance Information

Primary Insurance ______________________

Name of Policy Holder ______________________ Policy Holder DOB ____________

Relationship to Policy Holder ______________________

Secondary Insurance ______________________

Name of Policy Holder ______________________ Policy Holder DOB ____________

Relationship to Policy Holder ______________________

Additional Insurance ______________________

Name of Policy Holder ______________________ Policy Holder DOB ____________

Relationship to Policy Holder ______________________

I understand that the physicians at Raleigh Ophthalmology do not participate in any separate vision plans.
I understand and agree that I am ultimately responsible for payment. I certify that this information is true and correct to the best of my knowledge.

______________________ ____________

Signature of Patient or Guarantor Date