



CAROLINA CATARACT & LASER CENTER

PATIENT REGISTRATION FORM

Date: _____

Patient Name: _____

Address: _____ City, State, Zip: _____

Date of Birth: _____ Gender: Male () Female ()

Marital Status: Married () Single () Divorced () Separated () Widowed ()

SOCIAL SECURITY NUMBER: _____

Email Address: _____

Home Number: _(____)_____

Work Number: _(____)_____

Cell Number: _(____)_____

Who is your Employer? _____ Employer's Phone Number: (____)_____

What Is Your Pharmacy? _____ Pharmacy Phone Number: _(____)_____

Emergency Contact Name: _____ Emergency Contact #: _(____)_____

Primary Insurance: _____ Secondary Insurance: _____

Sponsor's name: _____ Sponsor's name: _____

Sponsors Date of Birth: _____ Sponsors Date of Birth: _____

Sponsors SSN: _____ - _____ - _____ Sponsors SSN: _____ - _____ - _____

Who can we thank for referring you? _____

GUARDIAN/PARENT INFORMATION IF PATIENT IS A MINOR:

Name: (mother) _____ Name: (Father) _____

SSN: _____ SSN: _____

Home Phone: _____ Home Phone: _____

Work Phone: _____ Work Phone: _____

I hereby authorize release of any medical information to process my insurance claim and also ASSIGN to the DOCTOR all payments from my insurance for services rendered. I understand and agree to the above conditions.

SIGNATURE

DATE