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: _____

Primary Number: _(_____)_____ **Cell Number**: (____)_____

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

Who is your Primary Care Doctor? _____ **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