HORIZON EYE SPECIALISTS
& LASIK CENTER

PATIENT REGISTRATION SHEET

PLEASE PRINT:

Mr. Mrs. Miss Ms: ____

FIRST M.I. Last(name)

Social Security Number: ____________________ **Date of Birth:** ____________________

Home Phone: ______________ **Work Phone:** ______________ **Cell Phone:** ______________

Address: ______________________ __________ **Apt#**_____**E-Mail:**____________________

City: ______________________________ **State:** _______ **Zip Code:** ______________

Sex: M F **Marital Status: Single Married Divorced Widowed**

Family Physician: ____________________ **Phone Number:** ____________________

Referred By: ____

Patient's Employer: ____________________ **Occupation:** ______________ **Are You Retired: Yes No**

Patient's Spouse: ____________________ **Spouse Phone Number:** ____________________

Person to Notify in Case of Emergency: ______________ **Relationship:** _______ **Phone:** __________

PLEASE PRESENT YOUR INSURANCE CARD AND IDENTIFICATION TO BE COPIED BY THE RECEPTIONIST

Insurance: Please list the subscriber if other than the patient. List your primary insurance company first.

Primary 1. ________________ **Subscriber:** ________________ **Subscribers DOB:** ___________

Secondary 2. ________________ **Subscriber:** ________________ **Subscribers DOB:** ___________

Person Responsible for Payment of Account (if different from above): ____________________

Address (if different from above): ____________________ **City:** _________**State:** ____ **Zip:** _____

I authorize the release of my medical records to my primary care physician and I authorize Horizon Eye Specialists to release any information regarding my medical history to my insurance company, if so requested.

I give permission to Horizon Eye Specialists to leave a message at my home. Messages may contain information regarding appointments, glasses or contact lenses, accounts receivable or results of tests. YES _____ NO _______

I also give permission to discuss any of my personal or medical information to the person(s) listed below. If no names are listed, I understand that no information will be given other than the brief messages listed above. I have the right to change this decision at any time with written or verbal notice to Horizon Eye Specialists & Lasik Center:

__________________ __________________ **Patient Signature:** ______________ **Date:**__________