THE REGIONAL EYE CENTER®
Always looking ahead.

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Last name:	**First:**		**Middle:**	**Nickname:**	
Is this your legal name? ❑ Yes ❑ No	**If not, what is your legal name?**	**Social Security No.:** / /	**Birth date:** / /	**Age:**	**Sex:** ❑ M ❑ F
Mailing Address *(Send statements to)*:		**City:**	**State:**	**Zip Code:**	
Secondary Address *(If applicable)*:		**City:**	**State:**	**Zip Code:**	
Marital status (circle one) Single / Mar / Div / Sep / Widow(er)		**Primary Care Physician:**			
Home Phone: ( )	**Cell Phone:** ( )		**Other Phone No.:** ( )		
Email Address:					

Referred to clinic by (*please check one box*):

❑ Physician *(Name)* _____ ❑ Hospital *(Name)*_____

❑ Family ❑ Friend/Family Member ❑ Insurance Plan ❑ Yellow Pages ❑ Website/Internet ❑ Other

Occupation:	**Employer:**	**Employer Phone No.:** ( )

Does the patient require a caregiver: ❑ No ❑ Yes **If yes, name of Primary Caregiver:**

The TN Dept. of Health requires us to ask the following questions:

Does the patient have a language barrier? ❑ No ❑Yes - *if yes please specify:*

Race *(please check one box)*	❑White/Caucasian	❑ Black/African American	❑ Native American/Alaskan
❑ Asian Pacific Islander	❑ Other Race	❑ Unknown Race	❑ Decline to Specify

Ethnicity *(please check one box)*	❑ Hispanic Origin	❑ Non-Hispanic Origin	❑ Unknown	❑ Decline to Specify

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IF THE PATIENT IS A MINOR, PLEASE PROVIDE THE FOLLOWING INFORMATION		
Father's Name:	**Address if different from patient:**	**Birth date: / /** **Phone No.: ( )**
Mother's Name:	**Address if different from patient:**	**Birth date: / /** **Phone No.: ( )**
Other Legal Guardian:		

INSURANCE INFORMATION				
Person responsible for Bill: ❑ Self ❑ Spouse ❑ Parent (*Please Circle: Father / Mother*) ❑ Other				
Is this patient covered by insurance? ❑ Yes ❑ No **If yes, name of primary insurance:**				
Subscriber's Name:	**Subscriber's S.S. No.:**	**Birth date: / /**	**Group no.:**	**Policy no.:**
Subscriber's Employer:	**Employer address:**		**Employer phone no.: ( )**	
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other				
Name of secondary insurance *(if applicable):*	**Subscriber's name:**		**Group no.:**	**Policy no.:**

SIGN AND DATE

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize The Regional Eye Center or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature ***Date***