SUGIKI•PORTIS EYE CENTER REGISTRATION FORM

Patient Information

Patient's Name (first name, middle name, last name):	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.			
Email Address:	Social Security No:	Birthdate: / /	Age:	Sex: ☐ M ☐ F
Street Address:	Home Phone: ( ) -	Cell Phone: ( ) -		
City:	State:	Zip Code:		
Occupation:	Employer:	Employer Phone: ( ) -		

Responsible Party Information (if different than above)

Name (first name, middle name, last name):	Social Security No:	Birthdate: / /	Sex: ☐ M ☐ F
Street Address:	City:	State:	Zip Code:
Relationship to Patient	Home Phone: ( ) -	Cell Phone: ( ) -	

Insurance Information

Name of PRIMARY Insurance & ID #:	Name of SECONDARY Insurance and ID #:

Primary Care Physician (PCP)

Name:	Address:	Phone: ( ) -

Optometrist (OD)

Name:	Address:	Phone: ( ) -

Referring Doctor (other than primary care physician & optometrist)

Name:	Address:	Phone: ( ) -

In Case of Emergency

Emergency Contact (not living at same address):	Relationship:	Home Phone: ( ) -	Cell Phone: ( ) -

Are you Interested in? (please check ALL appropriate boxes)

☐ decreasing your need for reading glasses ☐ LASIK ☐ cosmetic options (botox, demal fillers, eyelid lifts, etc.)

How did you hear about Sugiki•Portis Eye Center? (please check ALL appropriate boxes):

☐ family/friend (please specify person) ☐ doctor (please specify doctor) ☐ website (please specify site) ☐ insurance plan

☐ radio (please specify radio station) ☐ newspaper ad (please specify paper) ☐ yellow pages ☐ other (please specify other)

Pharmacy

Name:			
Street Address:	City:	State:	Zip Code:

Patient Signature: ______________________________________ Date _______/_________/________