# Reingold Eye Center

## Patient Registration Sheet <u>(Please Print)</u>

Patient Name: _____ Date: _____
(Circle one: Mr. Ms. Mrs. Miss)

Address: _____

_____
City State Zip

Home Phone: _____ Work: _____ Cell: _____

Cell Phone Carrier:_____ (*to receive an appointment reminder by text message*)

Social Security #: _____ Date Of Birth: _____

**E-Mail**: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ S ☐ M ☐ D ☐ W ☐DP

Spouse / Parent Name: _____

Responsible Party: _____ Relationship: _____

Employed By: _____ Occupation:_____

Address: _____

Referred By: _____ Phone #: _____

Patient's Primary Care Physician: _____Phone #: _____

******In Case Of Emergency please contact*** (NAME): _____

Phone #: _____ Relationship: _____

Insurance: (Primary) _____

Secondary, if applicable: _____

*I authorize the release of any medical information necessary to process this claim, and authorize the release of payment for medical benefits to my physician. I understand I am financially responsible to said doctor for all charges. We do not render services on the assumption that your charges will be paid by your insurance company.*

**I have been informed, and understand, that if my eyes are being dilated my vision will be blurred for approximately 4 hours and I may not be able to drive during this time.**

1. Patients signature: _____ Date: _____
2. Patients signature: _____ Date: _____
3. Patients signature: _____ Date: _____