RIDDLE EYE ASSOCIATES **PATIENT REGISTRATION**

Name:
Address:

Phone (h):
(c):
(w):
Are you… employed, a student, retired, disabled, other (circle one)
Employer/School
Address

Phone

Family Doctor
Address

Phone

Referring Doctor
Address

Phone

Check one: □ Mr. □ Mrs. □ Miss □ Dr.
Date of Birth:
Sex: M / F
Social Security #:

Marital Status:
Partner's Name:
Address (if different)

Phone (h)
(c)
(w)
Partner's Employer
Address

Phone

How did you hear about us?

Pharmacy Information
Name _____
Address _____

Phone # _____

Medical Insurance Information

With whom may we discuss your medical condition(s)?
Name: _____ Relation: _____ Phone: _____
Name: _____ Relation: _____ Phone: _____

I request that payment be made on my behalf by my medical carrier, to Riddle Eye Associates for services furnished by my physician. I also authorize the staff of Riddle Eye Associates to forward medical records needed to determine these benefits be paid.

Signature: _____ Date _____

Email Address (If you have one) _____