*** Please fill out this form and email to info@eyecarenewyork.com or print and bring it to your appointment ***

Eye Care
ON 5TH AVENUE
NEW YORK

REGISTRATION FORM

Today's Date: _____

Last Name _____ First Name _____ MI _____

Mr. ___ Mrs. ___ Ms. ___ Dr. ___

Male ___ Female ___

Race: [ ] African American [ ] Asian [ ] Caucasian
[ ] Hispanic [ ] Native American [ ] Other _____

Date of Birth _____ Age _____

Ethnicity: _____

Primary Language: _____

Social Security Number _____ E-Mail Address _____

Pharmacy Name: _____

Street Address _____ Pharmacy Address: _____

Apartment Number _____

Pharmacy Telephone: _____

City _____ State _____ Zip Code _____

Contact Preference for Healthcare Reminders: Phone E-Mail

Primary Phone _____ Secondary Phone _____

Occupation/Employer _____ Work Phone Number _____

Primary Care Physician's Name (PCP) (REQUIRED)

PCP's Address _____ PCP's Telephone Number _____

Referring Physician: _____ _____ _____
First Name Last Name Address/ Telephone Number

In case of an emergency, please contact: _____ _____
Name of Person Relationship to you

_____ _____
Contact's Primary Phone Contact's Secondary Phone

How did you hear about us? _____

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 Fromer Eye Centers or insurance company to release any information required to process my claims. Payment is expected at the time of the visit unless we participate with your insurance plan. Any copayment required under your plan is due a time of visit. I have received the Notice of Privacy Practices and I have had an opportunity to review it, and take a copy for my records.

_____ _____
PATIENT/GUARDIAN SIGNATURE DATE