Patient Registration Information (please print)

Eye Care Group

Patient Name: _____ Gender: _____
(first) (middle) (last)

Address: _____ City: _____ State: _____ Zip: _____

Birthdate: _____ Patient Social Security Number: _____

Home Phone: _(_____)_____ Cell Phone: _(_____)_____

Patient's Employer: _____ Employer Phone Number: _(_____)_____

Patient's Email Address: _____

Primary Care Provider (Doctor): _____ Phone Number: _(_____)_____

Marital Status (please circle): Single / Married / Divorced / Separated / Widow

Spouse Name: _____ Spouse Birthdate: _____

Responsible Party (Complete Only for Patients Under the Age of 18)

Parent/ Guardian Name: _____ Birthdate: _____

Address: _____ Social Security Number: _____

Vision Insurance Information

Insurance Company Name: _____ Policy Number: _____

Policy Holder Name: _____ Birthdate: _____

Relationship to Patient: _____ Policy Holder's Employer: _____

Medical Insurance Information

Insurance Company Name: _____ Policy Number: _____

Policy Holder Name: _____ Birthdate: _____

Relationship to Patient: _____ Policy Holder's Employer: _____

The Eye Care Group is required by law to maintain the privacy of your health information and to provide you with a written notice of our legal duties and privacy practices with respect to that information. A copy of our policy is available on request from the receptionist who assists you during your check in and registration. We also have a copy of the policy in our waiting area and on our website, www.ecg2020.com. With the signature below, I agree that I have been given the opportunity to read and receive a copy of the Eye Care Group Notice of Privacy Practices.

Patient/ Guardian Signature: _____ Date: _____