WILKINSON Eye Center

Patient Registration **Appt:** _____ **at** _____

24 hour notice required to avoid a $25 cancellation fee

Please complete and bring to your exam

Name: _____ ❑ M ❑ F DOB: _____ Age: _____
Last First MI

SS#: _____

Home #: _____ Work #: _____ Mobile #: _____

I prefer to be reached at: ❑ Home # ❑ Work # ❑ Mobile # E-Mail: _____

Address _____
Street City St ZIP

Emergency Contact: _____ Phone _____
Someone who does not live with patient

Patient's Employer: _____ Referred By: _____

Insurance Information:

Primary Medical Insurance: _____ Policy Holder's Employer: _____

Policy Holder Name: _____ DOB: _____

Policy Holder SS#: _____ Patient Relationship to Policy Holder: ❑ Self ❑ Spouse ❑ Dependent

Secondary Medical Insurance: _____ Policy Holder's Employer: _____

Policy Holder Name ***(if different than Primary):*** _____ DOB: _____

Policy Holder SS#: _____ Patient Relationship to Policy Holder: ❑ Self ❑ Spouse ❑ Dependent

Vision Insurance: _____

Policy Holder SS#: _____ Patient Relationship to Policy Holder: ❑ Self ❑ Spouse ❑ Dependent

Authorization to discuss my medical condition:

I authorize _____
Name (s)

Relationship(s) to me _____
to discuss my medical condition with Wilkinson Eye Center doctors or their designee and to obtain test results on my behalf.

Signature: _____ Date: _____

I have received a copy of the *Wilkinson Eye Center, P.C.* Notice of Privacy Practices for Protected Health Information.

Signature: _____ Date: _____

Staff Initials: _____

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