Hauser-Ross EYE INSTITUTE Lakeside EYE GROUP

Patient Registration Form

Patient Information				
Name (Last, First, Middle) **Circle one:** Mr. Mrs. Miss Ms.		**SS#**	**Date of Birth**	**Sex**
Local Address		**Permanent Address** (if applicable)		
City, State, Zip		**City, State, Zip**		
Home Phone	**Cell Phone**	**ER Contact Phone**	**ER Contact Name**	
Email Address	**Race:** ❑ American Indian or Alaskan Native ❑ Asian ❑ African American ❑ Native Hawaiian or Pacific Islander ❑ Caucasian ❑ Other			
Ethnicity ❑ Hispanic ❑ Non-Hispanic or Latino	**Primary Employer Name**		**Work Phone**	
Employer Address		**Employer City, State, Zip**		

Responsible Party Information				
Name (Last, First, Middle)		**SS#**	**Date of Birth**	**Sex**
Local Address		**City, State, Zip**		
Home Phone	**Cell Phone**	**Relationship to Patient** ❑ Power of Attorney ❑ Guardian		

Insurance Information		
Name of Insurance Company	**Name of Policy Holder**	
Address (If different from above)	**SS#**	**Date of Birth**

Secondary Insurance Information (If applicable)		
Name of Insurance Company	**Name of Policy Holder**	
Address (If different from above)	**SS#**	**Date of Birth**

Who is your optometrist? _____ **City** _____

Who is your primary care physician? _____ **City** _____

Who may we thank for helping you choose Hauser-Ross Eye Institute for your eye care needs?

❑ **Friend/Family** _____ ❑ **Newspaper (name)** _____

❑ **Optometrist** _____ ❑ **Medical Doctor** _____

❑ **Other** _____ ❑ **Location** ❑ **Reputation** ❑ **Insurance**