



Columbia River Eye Center

Patient Registration

Patient Information

Account# _____

Last Name		First Name	
Address		City	State Zip
Male/Female	Date of Birth	Social Security #	
Primary Care Physician		Preferred Pharmacy	
Marital Status S/M/D/W	Spouse's Name and Date of Birth	Patient's Employer/Occupation	
(PLEASE CIRCLE WHICH PHONE NUMBER WE MAY USE FOR LEAVING MESSAGES AND FOR CONTACTING YOU ABOUT YOUR APPOINTMENTS, PRESCRIPTIONS, ETC.)			
Home Phone		Work Phone	Cell Phone
Preferred Language		Race	Ethnicity
Emergency Contact Name/Phone Number/Relation:			

Financial Responsibility For This Account (For minors or if other than patient)

Name and Date of Birth (subscriber of Insurance Policy)	
Who is the responsible party? (please circle) Mother Father Both Other _____	
Father's Full Name	Mother's Full Name
Address	Address
Date of Birth	Date of Birth
Social Security #	Social Security #
Contact Phone#	Contact Phone#
Referred By: Relative/Friend/Yellow Pages/Optometrst/Doctor	
Name of Referring Doctor or Person:	

INSURANCE AUTHORIZATION AND INFORMATION

I hereby authorize The Columbia River Eye Center to furnish information to insurance carriers concerning any illness and treatment, and fully assign payment directly to the doctor for services rendered. All the above information is true to the best of my knowledge. I understand I am liable for any and all charges insurance does not pay. I also agree to pay any collection and/or attorney fees that should arise from nonpayment.

Signature: (patient or guardian) _____ **Date:** _____