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	
By providing your email address you consent to being contacted by email to access your medical records via our patient portal. Email (please print clearly):			
Preferred Language	Race	Ethnicity	
Emergency Contact Name/Phone Number:			

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/Optometrist/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:** _____