REGISTRATION

Tower Clock Eye Center

Date: ______________________

Drivers license is required of the patient or legal guardian.

PERSONAL INFORMATION

☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed

Patient Name: ____
Last First Middle Initial

Date of Birth: ______________________ Social Security #: ______________________

Street Address: ____

Mailing Address: ____

City: ______________________ State: __________ Zip Code: __________

Email: ______________________ Home Phone: ______________ Cell Phone: ______________

Employer: ______________________ Work Telephone: ______________________

Spouse: ______________________ Phone: ______________________

INSURANCE INFORMATION: Policy holder name: ______________________

Policy holder DOB: ______________ Relationship to policy holder: Self Spouse Parent

Ethnicity: ☐ Hispanic or Latino
☐ Not Hispanic or Latino

Race: ☐ American Indian
☐ Asian
☐ African American
☐ White
☐ Other

Preferred Language: ______________________

Preferred Method of Contact:

☐ Phone ☐ Text ☐ E-mail

CONTACT INFORMATION (outside of household)

Name: ______________________

Relationship to patient: ______________________

Telephone: ______________________

PARENT/LEGAL GUARDIAN INFORMATION (If applicable or if patient is under 18.)

Name: ____
Last First Middle Initial

Relationship: ______________________ Social Security #: ______________________

Street Address: ____

City: ______________________ State: __________ Zip Code: __________

Home Telephone: ______________________ Cellular Telephone: ______________________