KOKOPELLI EYE INSTITUTE

OUR VISION IS TO CARE ABOUT YOURS

Patient Registration Form

How did you hear about our practice? (Information provided is strictly for marketing purposes and appreciation letters.)

Friend/Relative-Please List: _____ Yellow Pages ____

Doctor's Office– Name: _____ Established patient with practice ____

Newspaper- Name of Newspaper: _____ Other: _____

PATIENT INFORMATION

Legal Name:_____

First Middle Last

Sex: Male Female Date of Birth:____/____/_____ Social Security #:_____-_____-_____

Home address:_____

Street City State Zip

Mailing address (if different):_____

Street City State Zip

Phone: Home(_____) _____ Work:(_____) _____ Cell:(_____) _____

Email Address:_____

***We encourage you to share your email with us so we can communicate appointment reminders, provider special offer notices and eye-related health care tips. Use is for internal purposes only. Your email will not be shared with other entities or third party groups. _____ Initial here to authorize use of your email address.**

MARITAL INFORMATION

Marital status: Single Married Divorced Widowed

Spouse's Name: _____ DOB: _____/_____/_____ Social security #: _____

_____

MINOR INFORMATION (17 YEARS AND YOUNGER)

Legal Guardian/Parent Name: _____ Date of Birth: _____/_____/_____

Legal Guardian/Parent Social Security #:_____ Phone: (_____) _____

INSURANCE INFORMATION

Do you have insurance? Yes / No If yes, please completely fill out below to ensure payment

Primary insurance: _____ Secondary Insurance: _____

Relationship to policy holder: Self Spouse Parent Other

Social Security #: _____ Phone: (___) _____ Employer of Policy Holder: _____

Vision Insurance: _____ Policy Number: _____

In case of emergency whom should we notify? Name: _____ Phone: (_____) _____

Who is your primary care physician (PCP): _____

Referring Doctor Name: _____

BY SIGNING BELOW YOU ACKNOWLEDGE THE ABOVE INFORMATION PROVIDED IS TRUE AND CORRECT TO THE BEST OF YOUR KNOWLEDGE. YOU ALSO ACKNOWLEDGE YOU HAVE OBTAINED, UNDERSTAND, AND AGREE TO ABIDE BY THE GUIDELINES CONTAINED IN THE RELEASE INFORMATION AND PATIENT FINANCIAL POLICY.

_____ _____

SIGNATURE OF PATIENT/LEGAL GUARDIAN **DATE**