



# Registration Information

Please Print

(Office Use Only)

RP No. \_\_\_\_\_ Patient Account No. \_\_\_\_\_ Receptionist \_\_\_\_\_

Dr. \_\_\_\_\_ Appointment Date \_\_\_\_\_

## PATIENT INFORMATION

Have you or any member of your family ever been seen by a St. Paul Eye Clinic physician before?  Yes  No

Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
LAST FIRST MIDDLE INITIAL

Sex \_\_\_\_\_ Marital Status \_\_\_\_\_ Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Apt. No. \_\_\_\_\_ Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ E-mail Address \_\_\_\_\_

Home Telephone \_\_\_\_\_ Work Telephone \_\_\_\_\_ Cell Telephone \_\_\_\_\_

Primary Care Doctor \_\_\_\_\_ Clinic \_\_\_\_\_

Referred By (Doctor) \_\_\_\_\_ Address \_\_\_\_\_

## PARTY RESPONSIBLE FOR ACCOUNT PAYMENT *(if other than patient)*

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
LAST FIRST MIDDLE INITIAL

Apt. No. \_\_\_\_\_ Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ E-mail Address \_\_\_\_\_

Home Telephone \_\_\_\_\_ Work Telephone \_\_\_\_\_ Cell Telephone \_\_\_\_\_

## INSURANCE INFORMATION *Please present insurance card to receptionist*

### PRIMARY INSURANCE COMPANY

Group No. \_\_\_\_\_ Identification No. \_\_\_\_\_

### POLICYHOLDER INFORMATION

Name \_\_\_\_\_ Sex \_\_\_\_\_ Birthdate \_\_\_\_\_  
LAST FIRST MIDDLE INITIAL

Social Security No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Employer \_\_\_\_\_ Work Telephone \_\_\_\_\_

Apt. No. \_\_\_\_\_ Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

### SECONDARY INSURANCE COMPANY

Group No. \_\_\_\_\_ Identification No. \_\_\_\_\_

### POLICYHOLDER INFORMATION

Name \_\_\_\_\_ Sex \_\_\_\_\_ Birthdate \_\_\_\_\_  
LAST FIRST MIDDLE INITIAL

Social Security No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Employer \_\_\_\_\_ Work Telephone \_\_\_\_\_

Apt. No. \_\_\_\_\_ Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_