



PATIENT REGISTRATION FORM

148 13TH STREET S.W.
LARGO, FL 33770

6133 CENTRAL AVENUE
ST. PETERSBURG, FL 33710

3165 McMULLEN BOOTH ROAD
BLDG. A, SUITE I
CLEARWATER, FL 33761

OFFICE USE ONLY

ACCOUNT # _____

NAME: _____

PRIMARY ADDRESS: _____

CITY, STATE: _____ ZIP: _____

PHONE: _____ SOCIAL SECURITY #: _____

APPT. CONFORMATION CALLS MADE TO THIS PHONE#: _____

EMAIL ADDRESS: _____

DATE OF BIRTH: _____ SEX: _____ MARITAL STATUS: _____

SEASONAL ADDRESS: _____

CITY, STATE: _____ ZIP: _____

PHONE: (____) _____ ALTERNATE PHONE (____) _____

RETIRED DISABLED

EMPLOYER: _____ WORK PHONE: _____

WORK ADDRESS: _____

IN CASE OF EMERGENCY, CONTACT: _____

RELATIONSHIP: _____ PHONE: (____) _____ ALTERNATE PHONE (____) _____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT? (INCLUDING POWER OF ATTORNEY - POA)

NAME: _____

ADDRESS: _____

CITY, STATE: _____ ZIP: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

RELATIONSHIP OR POA: _____ PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: MEDICARE MEDICAID
 WORK COMPENSATION VSP
 HMO PPO
 OTHER _____

PLEASE NOTE: A COPY OF YOUR INSURANCE CARD(S) IS REQUIRED UNLESS YOU WISH TO BE TREATED AS A "CASH" PATIENT UNTIL THE COPIES ARE PROVIDED.

HOW DID YOU HEAR ABOUT THE EYE INSTITUTE OF WEST FLORIDA?

