Aurora EYE CLINIC

PATIENT REGISTRATION

Date:_____

PATIENT INFORMATION

Last Name | First Name | M.I. | Date of Birth | Sex

Address | City | State | Zip Code

Occupation | Phone | Email Address

Primary Care Physician | Primary Care Physician Address | Phone

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Race | Ethnicity | Language Preference

INSURANCE **PLEASE BRING INSURANCE CARDS TO FRONT DESK**

Primary Insurance Company | Member ID

Name of Policyholder | Group # | Date of Birth

Secondary Insurance Company | Member ID

Name of Policyholder | Policy Number | Date of Birth

GUARANTOR/PARENT/LEGAL GUARDIAN

Name | Address | Phone

EMERGENCY CONTACT

Name | Address | Phone