PATIENT REGISTRATION

Mr. Mrs. Ms. Dr. :_____
(Circle) First Name Middle Initial Last Name Nickname

Address: _____
Street City State Zip

Home Telephone #:_____ Work #: _____ Ext: _____

Cell#:_____ E-mail Address: _____

Date of Birth: _____ Sex: Male ___ Female: ___ Social Security #: _____

Marital Status: Single _____ Married _____ Widowed _____

Guarantor (Minor): _____ Relationship: _____

*Guarantor's Address: _____ Phone #: _____

*Guarantor's Social Security #: _____ Date of Birth: _____

Are you currently in a Skilled Nursing Facility? Yes _____ No _____

Name of Facility: _____

Facility Address: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Address: _____

Referred By: _____

Patient Employer/School: _____ Phone #: _____

Spouse/Guarantor Employer: _____ Phone #: _____

Emergency Contact: _____ Phone #: _____

Nearest Relative Not Living with You: _____ Phone #: _____

The following person/s may have access to my medical records: _____

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have read the notice of privacy practices of Center for Sight:

Patient/Guarantor Signature: _____ Date: _____