PACIFIC EYE CARE CENTER
1270 Arroyo Way, Walnut Creek, CA 94596
Phone:(925) 945-8188 **Fax:**(925) 945-0360
Website: www.pacificeyecarecenter.org

PATIENT REGISTRATION FORM

Please select which doctor you are seeing: □ Patricia Austin, MD □ Stephen Dentone, OD □ Rachel Kaneta, O.D.

Please write clearly, complete ALL sections & sign the bottom of the page

Patient Name: (Last) ________________________**(First)**_____________________**(M.I.)**_________**(Suffix)**____________

Birth Date:__________ **Sex:** □M □F **Social Security#**(if minor, list guardian's)**:last 4 digits only**_______**Driver's Lic. #:**________

If patient is a minor, please list guardian's name:____________________________**Birth Date:**_______**Relationship:**_______

Mailing Address:_______________________________________**City:**________________**State:**_________**Zip:**__________

Primary Phone:_____________________□Home□Work□Cell **Secondary Phone:**__________________________□Home□Work□Cell

Other Phone:______________________□Home□Work□Cell **E-mail:**____

PATIENT EMPLOYMENT INFORMATION: (if minor, list guardian's)

Occupation:_______________________**Employer:**________________________________**Phone:**_____________________

Work Address:____**City:**________________**State:**_________**Zip:**__________

Marital Status: □Single □Married □Divorced □Widowed □Legally Separated □Domestic Partnership □Minor

Name of Spouse/Partner:____**Age:**_________**Date of Birth:**___________ **Sex:** □M □F

Occupation:_______________________**Employer:**________________________________**Phone:**_____________________

Work Address:____**City:**________________**State:**_________**Zip:**__________

Referring Physician (if applicable)**:**____**Phone:**_____________________

Who may we thank for your referral besides your doctor?____

LOCAL EMERGENCY CONTACT: Please list someone who lives nearby that we can contact in case of an emergency on your behalf

Name:____**Relationship:**______________________**Phone:**______________

SECONDARY CONTACT: List someone we can contact who <u>does not live with you</u> and who can be reached in case we can't contact you

Name:____**Relationship:**______________________**Phone:**______________

Mailing Address:_______________________________________**City:**________________**State:**_________**Zip:**__________

INSURANCE INFORMATION:

Primary Insurance:________________________________**Policy #:**___________________________**Group#:**_____________

Insured's Name:___________________________________Social Security #:____________________Birth Date:_____________

Secondary Insurance:______________________________**Policy #:**___________________________**Group#:**_____________

Insured's Name:___________________________________Social Security #:____________________Birth Date:_____________

Vision Insurance:_________________________________**Policy #:**___________________________**Group#:**_____________

Insured's Name:___________________________________Social Security #:____________________Birth Date:_____________

I certify that the above information is correct to the best of my knowledge. I also understand that payments for all professional services rendered are ultimately the patient's responsibility.

Patient/Guardian Signature:____**Date:**______________________