

CREATIVE OPTICAL, LLC
2012 REGISTRATION FORM
(PLEASE PRINT)

Today's Date:			Primary Care Physician:		
PATIENT INFORMATION					
Patient's Last Name:			First Name:		Middle:
Birth Date:	Age:	SSN:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Street Address:			City:		State: Zip:
P.O. Box Address:				Home Ph: ()	
				Cell Ph: ()	
TEMPORARY WINTER ADDRESS:				Marital Status: Single, Married, Divorced.	
Occupation:		Employer:		Employer Phone Number: ()	
VISION INSURANCE INFORMATION					
Is this Patient covered by vision insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			Insurance:		
Policy Number:			Group Number:		Co-pay:
Subscriber's Name:	Subscriber's SSN:		Birth Date:	Patient relationship to subscriber: <input type="checkbox"/> Spouse <input type="checkbox"/> Dependant <input type="checkbox"/> Other	
MEDICAL INSURANCE INFORMATION					
Is this patient covered by medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			Insurance:		
Policy Number:			Group Number:		Co-pay:
Subscriber's Name:	Subscriber's SSN:		Birth Date:	Patient relationship to subscriber: <input type="checkbox"/> Spouse <input type="checkbox"/> Dependant <input type="checkbox"/> Other	
Please indicate other medical insurance (list on back if needed).			Insurance:		
Policy Number:			Group Number:		Co-pay:
Subscriber's Name:	Subscriber's SSN:		Birth Date:	Patient relationship to subscriber: <input type="checkbox"/> Spouse <input type="checkbox"/> Dependant <input type="checkbox"/> Other	
IN CASE OF EMERGENCY					
Name of local friend or relative: (not living at same address)			Relationship to Patient:	Home Ph: ()	Work Ph: ()
Referred to clinic by (Please check one box): <input type="checkbox"/> Doctor <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Yellow pages <input type="checkbox"/> Other					
Other family members seen here:					
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Creative Optical or insurance company to release any information required to process my claims.					
_____ <i>Patient/Guardian signature</i>				_____ <i>Date</i>	