THE EYE INSTITUTE OF UTAH
THE SURGICARE CENTER OF UTAH

PATIENT REGISTRATION FORM

PLEASE PRINT

Patient Name ______________________ ______________________ ______________________
Last First Middle Int.

Social Security # ______________________ Date of Birth ______________________

Sex: [ ] Male [ ] Female Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed

Mailing Address ____

City ______________________ State __________ Zip Code ______________

Phone Number ______________________ Daytime Phone Number ______________________

email Address ______________________________

Employer ______________________ Phone Number ______________________

Emergency Contact ____

Relation ______________________ Phone Number ______________________

How were you referred to us?

[ ] Radio [ ] Phone Book [ ] Insurance [ ] TV [ ] Employee
[ ] Newspaper [ ] Friend/Relative [ ] Valuepak [ ] Optical Shop [ ] Movie Theater
[ ] Health Fair [ ] Employer [ ] Drove By [ ] Web Site/Internet [ ] Current/Previous Patient
[ ] Doctor (First & Last Name) ______________________________

Primary Care Physician ____

Address/Phone # ____

Eye Care Provider ____

<u>For Minor Patients</u>

Responsible Party ____

Relation ______________________ Date of Birth ______________________

Phone Number (if different from above) ______________________________

Mailing Address (if different from above) ______________________________

City ______________________ State __________ Zip Code ______________

<u>Insurance Information:</u>

Name of Policy Holder (if different from above): ______________________________

Policy Holder's Date of Birth ______________ Employer ______________________

We will take a copy of your insurance card(s) at the front desk.

IT IS THE PATIENT'S RESPONSIBILITY TO VERIFY INSURANCE BENEFITS. WE BILL THE INSURANCE AS A COURTESY TO THE PATIENT. WITHOUT COMPLETE INSURANCE INFORMATION, WE HAVE NO ALTERNATIVE BUT TO SEND THE BILL TO THE PATIENT.

Updated 6/15/2011