



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 Merkley Patient
- Doctor (First & Last Name) _____ Current/Previous Patient

Primary Care Physician _____

Eye Care Provider _____

For Minor Patients

Responsible Party _____

Relation _____ Date of Birth _____

Phone Number (if different from above) _____

Mailing Address (if different from above) _____

City _____ State _____ Zip Code _____

Insurance Information:

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.