T&KEI

TERRY & KIM EYE INSTITUTE

Advancing Eye Care with Research and Compassion

MRN#:

Please mark preferred contact method:
[ ] Telephone [ ] Text [ ] Email

REGISTRATION FORM

PATIENT INFORMATION

Patient's Name (First name, Middle name, Last name) ****As listed on insurance*:**		**Birth Date:**	**Social Security Number:**
Preferred Name:	**Marital status:** **[ ] Single [ ] Married [ ] Divorced** **[ ] Domestic Partner [ ] Widowed**	**Sex:** **[ ] Male** **[ ] Female**	**Race/Ethnicity: [ ] Asian** **[ ]African American[ ]Hispanic** **[ ] Pacific Islander [ ] Other**
Street Address:		**Primary phone:**	**Secondary phone:**
City:		**State:**	**Zip code:**
Email:		**Occupation:**	**Employer:**

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT THAN ABOVE)

Name (First name, Middle name, Last name)		**Birth date:**	**Social security:**
Sex: **[ ] Male [ ] Female**	**Relationship to patient:**	**Phone number:**	**Street address:**
City:	**State:**	**Zip code:**	**Email address:**

INSURANCE INFORMATION

Name of primary insurance and ID number:	**Name of secondary insurance and ID number:**
Medical Group (if you have an HMO plan)	**Vision plan and ID number:**

PRIMARY CARE PHYSICIAN (PCP)

Name:	**Address:**	**Phone number:**

OPTOMETRIST (OD)

Name:	**Address:**	**Phone number:**

IN CASE OF EMERGENCY

Contact (Not living at same address):	**Relationship:**	**Phone number:**

PHARMACY

Name and address:	**Phone:**	**Fax:**

HOW DID YOU HEAR ABOUT US

[ ] Family/Friend [ ] PCP [ ] Website [ ] Insurance Plan [ ] Optometrist

Patient Signature:_____ **Date:**_____