Center for Advanced Eye Care

1104 N. Division Street
Carson City, NV 89703
(775) 882-9123

1673 Lucerne Street, Suite B
Minden, NV 89423
(775) 782-5523

Patient Registration Information:

Name:_____ Date of Birth:_____
Address:_____ City: _____ State:_____ Zip:_____
Mailing Address: _____ City:_____ State:_____ Zip: _____
Home Phone: _____ Employer:_____ Work Phone:_____
Cell Phone: _____ SSN :_____ Gender: Male [ ] Female [ ]
Marital Status: Married [ ] Single [ ] Widowed [ ] Divorced [ ]

Primary Care Physician: _____ **Referring MD/Optometrist:**_____

Spouse or Parent Information:
Name: _____ Relationship: _____
Address:_____ City:_____ State: _____ Zip:_____
Home#:_____ Work #:_____ Cell#_____DOB: _____ SSN:_____
Employer: _____ Employer Phone: _____

Insurance Information:
Name of Insurance: _____ Name of Policy Holder: _____
Insurance ID#:_____ Group #: _____ Employer: _____
Policy Holder DOB: _____ SSN :_____
Relationship to insured: Self [ ] Spouse [ ] Child [ ] Other [ ] _____

Secondary Insurance Information:
Name of Insurance: _____ Name of Policy Holder: _____
Insurance ID#:_____ Group #: _____ Employer: _____
Policy Holder DOB: _____ SSN :_____
Relationship to insured: Self [ ] Spouse [ ] Child [ ] Other [ ] _____

Emergency Contact (not living with you) Name: _____
Relationship to you: _____ Home #: _____ Cell #: _____

Additional Information: **Email address:** _____

CALLS & MESSAGES:
You can leave messages at home Yes [ ] No [ ]
You can leave messages at work Yes [ ] No [ ]
You can leave message on cell Yes [ ] No [ ]

Requested Pharmacy :_____
Preferred Language: English [ ] Spanish [ ] Other [ ] _____

Ethnicity: Caucasian [ ] Hispanic [ ] American Indian [ ] Asian [ ] Other [ ] _____

I hereby consent to treatment and give authorization for payment of insurance benefits to be made directly to Center for Advanced Eye Care and any assisting physicians or optometrists for services rendered. The above information I have provided is current and accurate. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. I hereby authorize this healthcare provider to release any information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be valid as original.

Signature: _____ **Date:** _____