EYE CARE GROUP

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION				
Patient last name: First: Middle:			Patient DOB: / /	
Patient Social Security No:		❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Spouse Name:			Spouse DOB: / /	
Street address:	Home phone no.: ( )		Cell phone no.: ( )	
P.O. box:	City:	State:	ZIP Code:	
Employer Name:	Employer phone no.: ( )			
Email address:				
Primary Care Provider Name: Address: Phone: ( )				

Responsible Party (Complete only for patients under the age of 18)	
Parent or Guardian Name:	Parent or Guardian Address:
Parent or Guardian DOB: / /	Parent or Guardian Social Security no.:

Vision Insurance Information	
Insurance Company Name	Policy Number
Policyholder DOB / /	Relationship to Policyholder

Medical Insurance Information		
Insurance Company Name	Policy Number	Group Number
Policyholder DOB / /	Relationship to Policyholder	

The Eye Care Group is required by law to maintain the privacy of your health information and to provide you with a written notice of our legal duties and privacy practices with respect to that information. A copy of our policy is available on request from the receptionist who assists you during your check in and registration. We also have a copy of the policy in our waiting area and on our website, **www.ecg2020.com**. With the signature below, I agree that I have been given the opportunity to read and receive a copy of the **Eye Care Group** Notice of Privacy Practices.

Date: _____ Patient/Guardian: _____