CENTRAL VALLEY EYE MEDICAL GROUP, INC
PATIENT REGISTRATION

Referred by:_____ **Family doctor:**_____

Patient Name._____ Today's Date_____
Last First Middle

Home Address_____
City_____State_____ Zip Code_____

Home Phone_____Cell Phone_____
E-mail address_____ Marital Status Single Married Divorced Widowed

Social Security Number_____ Date of Birth_____ Age _____ Gender M F

Employer/Parent's Employer_____Occupation_____

Work Address_____Work Phone_____

City_____State_____Zip Code_____

Spouse name (Parent name if minor)_____Spouse/Parent Work Phone_____

Person to notify in case of emergency (other than spouse)_____

Phone number (s)_____Relationship_____

Primary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		**Relationship to Patient**
Social Security Number	Date of Birth	Employer

Secondary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		**Relationship to Patient**
Social Security Number	Date of Birth	Employer

I certify that I (or my dependent) have insurance coverage as stated above and agree to have insurance payments made directly to Central Valley Eye Medical Group to be applied to my account for services rendered. I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment. I am aware there may be additional collection and/or attorney's fees if my account is referred for collection. For patients covered
by Medicare the patient will be responsible for 20% of the Medicare allowable charges plus any deductibles, coinsurance and uncovered charges that apply.

_____ _____

Patient's signature **Today's date**