PALMETTO CATARACT & EYE SPECIALISTS

PATIENT REGISTRATION FORM

PATIENT INFORMATION (Please use full legal name, no nicknames)

Last name	First Name	M.I.
Social Security # - -	Date of Birth	Sex M / F
Address	City	State/zip code
Home Phone # ( ) -	Cell Phone # ( ) -	E-mail:
Preferred contact method Home / Cell / Work / Email	Marital Status Single Married Widowed Divorced	Employment Status No Full Time Part Time Retired Student
Name of Employment or School	Work # ( ) -	

GUARANTOR (RESPONSIBLE PARTY) INFORMATION SAME AS ABOVE: YES NO (if yes, skip this section)
IF PATIENT IS A MINOR, PLEASE FILL OUT

Last name	First Name	M.I.
Social Security # - -	Date of Birth	Sex M / F
Address	City	State/zip code
Home Phone # ( ) -	Cell Phone # ( ) -	E-mail:
Preferred contact method Home / Cell / Work / Email	Marital Status Single Married Widowed Divorced	Employment Status No Full Time Part Time Retired Student
Name of Employment or School	Work # ( ) -	

INSURANCE INFORMATION - PLEASE PRESENT YOUR CARD(S) AT THE FRONT DESK

EMERGENCY CONTACT Name Relationship Phone # ( ) -

HOW DID YOU HEAR ABOUT US?