WOLSTAN EYE ASSOCIATES
PATIENT REGISTRATION
Please Print

Patient's Name:_____ Date of Birth:____-_____-_____ Age:_____
Last First Middle

Address:_____ City:_____ State:____ Zip:_____

Home Phone:(_____)_____ Cell Phone:(_____)_____

❑ Single ❑ Married ❑ Widowed ❑ Male ❑ Female Soc. Sec. #:_____-_____-_____

Email:_____ Driver's Lic. #:_____

How were you referred to our practice? ❑ Family/Friend ❑ Doctor ❑ Insurance ❑ Phone Book
❑ Wolstan Staff ❑ Internet ❑ Other:_____

Whom may we thank for referring you?_____

Patient Employer:_____ Occupation:_____

Work Address:_____ City:_____ State:____ Zip:_____

Work Phone:(_____)_____ Ext.:_____

If the patient is a dependent or minor, the following pertains to the insured

Insured's Name:_____ Relationship:_____

Insured's Employer's Name:_____ Phone:(_____)_____

Work Address:_____ City:_____ State:____ Zip:_____

Insured's Soc. Sec. #:_____-_____-_____ Insured's Date of Birth:_____-_____-_____

Personal Physician:_____ Phone:(_____)_____

Address:_____ City:_____ State:____ Zip:_____

Emergency Contact:_____ Phone:(_____)_____

Emergency Contact:_____ Phone:(_____)_____
(Not living with you)

AUTHORIZATION AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby consent and authorize the performance of all treatments, surgery and medical services by the physicians and staff which they may deem advisable and to furnish information relating to all claims for benefits submitted on my behalf and/or my dependents. I hereby assign all payments for medical services rendered or devices to be rendered. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature:_____ Date:_____ Relationship:_____