KETCHIKAN Eye Care Center
Advanced Vision & Health Care for Your Family's Eyes

Patient Registration Form

GENERAL INFORMATION:

First, Last MI, Preferred Name: _____

Mailing Address: _____

City, State, Zip: _____

Phone, Type: _____

Phone 2, Type: _____

Email: _____

Date of Birth: _____ Male/Female: _____

Patient Social Security Number: _____

Occupation, Employer: _____ ☐full-time ☐part-time

Marital Status: ☐Married ☐Single ☐Divorced ☐Legally Separated ☐Widowed

Emergency Contact Person, Phone: _____

Insurance Information:

Vision Insurance: _____ Member ID#: _____

Member Name: _____

Member Date of Birth: _____

Medical Insurance: _____ ID#: _____

Member Name: _____

Member Date of Birth: _____

Member Employer: _____

Your Relationship to Member: ☐Spouse ☐Child ☐Other: _____

Mailing address of Member: (if different then patient) _____

_____

PLEASE PRESENT ALL INSURANCE CARDS TO FRONT DESK BEFORE APPOINTMENT