Friedrich Eye Associates, PLLC

PATIENT REGISTRATION

Patient Name				**Salutation**	
Birth Date		**Age**		**Birth State**	
Sex				**SS #**	
CURRENT ADDRESS					
Address					
ADDRESS YOUR INSURANCE COMPANY HAS ON FILE				**☐ Same As Above**	
Address					

COMMUNICATION					
Home Phone #		**Work Phone #**		**Extension**	
Cell Phone #		**Carrier**			
Email					

REFERRAL SOURCE					
Referring MD		**Phone #**		**Fax #**	
Address		**City and Zip**			
Primary MD		**Phone #**			
Address		**City and Zip**			

GOVERNMENT REQUIRED INFORMATION **Check One in EACH Section**			
Primary Language	☐ English ☐ Spanish ☐ French ☐ Other: _____		
Race	☐ American Indian or Alaska Native ☐ Black or African American ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other Race ☐ Decline to Answer	**Ethnicity**	☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Unknown ☐ Decline to Answer

INFORMATION			
Marital Status		**Special Needs**	
Occupation		**Employer**	
Employer Address		**Employer Phone #**	

ACCOUNT RESPONSIBLE					□ Same As Above
Responsible			**Birth date**		
Pt. Relationship			**SS #**		
Address					
Home Phone #		**Work Phone #**		**Extension**	
Email					

PRIMARY INSURANCE			
Name		**Group Name**	
ID #		**Group #**	
Address			
Phone			
Insured		**Date of Birth**	

SECONDARY INSURANCE			
Name		**Name**	
ID #		**Group #**	
Address			
Phone			
Insured		**Date of Birth**	

EMERGENCY CONTACT		
Name	**Relationship**	**Phone #**