Patient Registration
Goodyear Eye Specialists

Name: _____ Today's Date: _____
Last First MI Month/Date/Year

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____ Social Security Number: _____

Age: _____ Date of Birth: _____ Male: _____ Female: _____ Marital Status: S M W D
Month/Date/Year

Email Address: _____

Ethnicity: [ ] American Indian or Alaska Native [ ] Asian [ ] Black or African American

[ ] Native Hawaiian or other Pacific Islander [ ] White [ ] Hispanic[ ] Two or more Races (Not Hispanic or Latino)

Employed By: _____ Retired: _____ Occupation: _____

Address: _____ Work Phone: _____

Spouse or Parent's Name: _____

Emergency Contact: _____ Relationship: _____

Address: _____ Telephone: _____

Different person responsible for payment? _____ Relationship: _____

Address: _____ Telephone: _____

Date of Birth: _____ Social Security Number: _____

If you are married, what is the date of birth of your spouse? _____

What is the name of your primary care physician? _____ M.D. D.O.

What is your pharmacy name, address, and zip code? _____

How did you hear about our office? Internet Friend Family Member Hospital Health Plan Directory

Another patient, who? _____ Another doctor, who? _____

Health Insurance Information:

Do you have health insurance? Yes No Medicare? Yes No **Your Medicare Number**: _____

If not Medicare, what is the name of your primary medical insurance? _____

Non-Medicare primary insurance holder's name: _____
Last First MI

Do you have secondary medical insurance? Yes No Secondary Insurance Name: _____

For billing purposes, our receptionist may wish to make a copy of your insurance plan cards.