PATIENT REGISTRATION SHEET

Patient (Mr., Mrs.)
Name (Miss, Ms.) _____
Address: _____
(City) _____ (State) _____ (Zip) _____
Home Phone: _____ Work Phone: _____ E-Mail: _____
Sex: ❑ M ❑F Cell Phone: _____
Date of Birth: _____ / _____ / _____ Social Security # _____ / _____ / _____
Referred by: (How did you hear about us?) _____
Patient's Family Physician: _____
Patient employed by: _____ Retired? ☐ Occupation _____
Address: _____
Spouse's Name: _____
Employed by: _____ Phone # _____
Emergency contact not living with you: _____ Relationship _____
Address: _____ Phone # _____
(City) _____ (State) _____ (Zip) _____
Insurance with: 1. _____ Policy # _____
2. _____ Policy # _____
Policy Holder Name _____ DOB: _____ SS# _____
Address: _____ Phone # _____
(City) _____ (State) _____ (Zip) _____

GIVE YOUR INSURANCE I.D. CARD TO THE SECRETARY

1. I hereby authorize payment directly to The Wright Eye Center, P.C., for the surgical and/or medical benefits, if any, otherwise payable to me under terms of my insurance.
2. I understand that I am ultimately responsible for services rendered even though I may be covered by medical, workman's compensation insurance, or a private agreement with another party.
3. I hereby authorize photocopies of this form to be as valid as the original.

SIGNATURE: _____ Date: _____

JOHN R. WRIGHT, D.O.
BRANT R. GEHLER, O.D.
TIMOTHY M. REESE, O.D.

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CO SPRINGS, CO 80909

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