Fairmont Eye Care
Registration Form

Today's Date:_________________

Patient Information

Legal First Name:____________________M.I.________Last Name:______________________

Address:____
Street City State Zip Code

Telephone:(____)__________________ Social Security Number:_____________________
Cell: (____)____________________ Work: (____)____________________________

Date of Birth:___________________ Gender: M / F Marital Status: Married/Single/Divorced

Responsible Party and Billing Information

First Name:_______________________M.I._________Last Name:_______________________

Address:____
Street City State Zip Code

Telephone:(____)____________________ Social Security Number:______________________

Relationship to Patient:____________________________________

Employer:_____________________________________ Telephone:(____)__________________

Insurance Information

PRIMARY Insurance Company:____

Policy NO.:____________________________________Group NO.:_______________________
Subscriber Name:______________________________Subscriber DOB:___________________

Employer:__________________________________Relationship to patient:_________________

SECONDARY Insurance Company:____

Policy NO.:__________________________________Group NO.:________________________

Subscriber Name:_____________________________Subscriber DOB:____________________

Employer:_________________________________Relationship to patient:__________________

____ ______________________________
Patient/Responsible Party Signature Date