Patient Registration Data
Pocono Eye Associates, Inc.

*****How did you hear about us (New Patients Only - please circle one):*****

TV Internet Family/Friend Ins. Provider Phone Book Doctor Billboard Newspaper

Mr. Mrs. Miss Ms._____ Today's Date_____

Mailing Address _____City _____State _____Zip _____

Home Phone _____ Cell Phone _____

Unless otherwise notified in writing, I authorize Pocono Eye Associates to leave messages regarding appointments and/or billing at these phone numbers. We will never leave detailed information concerning medical diagnoses or medications.

E-Mail address _____

Physical Address if P.O. Box Number_____

SS Number_____ Date of Birth_____ Gender: M F X Marital Status: S M D W

Patient's (or Guardian's) Employer_____ Phone _____

Patient's Legal Guardian (if patient is a minor) _____Phone_____

Emergency Contact_____Phone_____

Referring Physician_____Phone_____

Family Physician_____ Phone_____

INSURANCE SUBSCRIBER'S INFORMATION

(IF NOT THE PATIENT)

Subscriber's Name_____ Phone_____

Date of Birth_____ Social Security Number_____

Subscriber's relationship to patient: Spouse Father Mother Other

*****PLEASE FILL OUT FORM IN ITS ENTIRETY. THANK YOU*****