Yuma Vision Center
QUALITY EYE CARE

PATIENT REGISTRATION- PLEASE PRINT CLEARLY

PATIENT NAME First Middle Last			DATE OF BIRTH	AGE
MAILING ADDRESS /PO BOX	APT. NO.	CITY	STATE	ZIP
SOCIAL SECURITY NO.	SEX ☐ M ☐ F	MARITAL STATUS ☐ S ☐ M ☐ D ☐ W	SPOUSE'S NAME	
HOME NUMBER	ALTERNATE NUMBER ☐ CELL ☐ WORK	EMAIL ADDRESS		
OCCUPATION	EMPLOYER			
RACE : ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic ☐ Native Hawaiian/ Other Pacific Islander ☐ White		ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Native Hawaiian/ Other Pacific Islander		
PREFERRED LANGUAGE:	COMMUNICATION PREFERENCE: ☐ TELEPHONE ☐ EMAIL ☐ POSTAL			
PRIMARY CARE PHYSICIAN	REFERRED BY			
EMERGENCY CONTACT/ RELATION TO PATIENT	EMERGENCY CONTACT PHONE NO.			

INSURANCE INFORMATION

PRIMARY INSURANCE	SUBSCRIBER	
SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SOCIAL SECURITY NO.	RELATIONSHIP TO SUBSCRIBER
SECONDARY INSURANCE	SUBSCRIBER	
SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SOCIAL SECURITY NO.	RELATIONSHIP TO SUBSCRIBER

FOR MINORS ONLY (Under age 18)

PARENT'S NAME	PARENT'S DATE OF BIRTH

You are ultimately responsible for payment in full of your account, not your insurance company. We can only make estimates regarding your insurance benefits based upon the information provided by you and your insurance company. In the event that your insurance company does not pay the amount expected, you will be billed for the balance. Please remember that you are responsible for any deductible.

I AUTHORIZE PAYMENT OF MEDICARE AND/ OR OTHER INSURANCE BENEFITS TO BE MADE DIRECTLY TO YUMA VISION CENTER FOR SERVICES PROVIDED TO ME. I HEREBY AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION TO MY INSURANCE COMPANIES AS IS NECESSARY TO PROCESS CLAIMS FOR SERVICES PROVIDED TO ME.

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SIGNATURE OF PATIENT/ LEGAL GUARDIAN **DATE**

I ACKNOWLEDGE I HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

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SIGNATURE OF PATIENT/ LEGAL GUARDIAN **DATE**