Twin Cities Eye
CONSULTANTS

Clinic Address:

Tel 612-999-2020

_____
Street Address

_____
City State Zip

PATIENT REGISTRATION FORM

Today's date:			
PATIENT INFORMATION			
Patient name:			Date of birth:
Address:			
Social Security #:	Cell phone:		Home phone:
Email:			Sex: F M
Primary doctor:			
Referring doctor:			
GUARANTOR INFORMATION			
Name:			Date of birth:
Address:			
Phone:	SS#:		Relation:
INTERPRETER			
Do you need an interpreter? Y N		Specify language here:	
How did you hear about us? Please circle			
TV Radio Internet Physician Relative Friend Insurance Other			
INSURANCE INFORMATION			
Primary insurance:		Secondary insurance:	
Subscriber name:	Date of birth:	Subscriber name:	Date of birth:
SS#:	Relation:	SS#:	Relation:
Vision plan:	Subscriber:	SS#:	Relation:
IN CASE OF EMERGENCY			
Name:	Relation:		Phone:
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Twin Cities Eye Consultants to release any information required to process my claims.			
Patient /Guardian signature			Date