

Commonwealth Eye Care Associates

Telephone: (804) 217-6363

*Dr. Andrew J. Michael, Dr. Shawn H. Hobbs, Dr. Joseph D. Iuorno, Dr. Tami A. Flowers, Dr. Meredith Diehl, Dr. Jonathan Noble, Dr. Drew Munro, Dr. Matthew Young, Dr. Brianna Easton***PATIENT REGISTRATION, CONSENT TO TREATMENT, AND PAYMENT AUTHORIZATION
PLEASE FILL OUT FORM COMPLETELY & PRINT CLEARLY**NAME _____ BIRTH DATE _____
LAST FIRST MI NICKNAME MONTH DAY YEARADDRESS _____
STREET CITY STATE ZIP

SEX: F M MARITAL STATUS Single Married Divorced Separated Widowed Other

RACE: Caucasian/ African American/ American Indian/ Asian Hispanic-Latino/ other _____

ETHNICITY: American/ Mexican/Japanese/Chinese/Asian/European/Latino/ other _____

PREFERRED LANGUAGE: _____ PATIENT'S SSN _____ - _____ - _____

EMAIL _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

WHICH NUMBER DO YOU PREFER WE CALL DURING BUSINESS HOURS? _____

EMPLOYMENT STATUS: FT PT RETIRED ACTIVE DUTY

EMPLOYER _____ OCCUPATION _____

PERSON WHO REFERRED ME TO THIS PRACTICE _____

OPTOMETRIST _____ LOCATED AT _____

PRIMARY CARE PHYSICIAN _____ PHONE _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

PHONE: _____ ALTERNATE/CELL PHONE: _____

DO YOU HAVE AN ADVANCED DIRECTIVE (LIVING WILL) OR DNR? YES or NO

NAME OF INSURANCE COMPANY OR HEALTH BENEFIT PLAN:

PRIMARY _____ Policy Holder Name _____

SECONDARY: _____ Policy Holder Name _____

TERTIARY: _____ Policy Holder Name _____

(Please provide your insurance cards to our receptionist)

POLICY HOLDER'S NAME (Spouse/Parent/Guardian) _____

POLICY HOLDER'S DATE OF BIRTH (Spouse/Parent/Guardian) _____

POLICY HOLDER'S SOCIAL SECURITY NUMBER (Spouse/Parent/Guardian) _____

Due to privacy regulations, please indicate below anyone that you want to allow to inquire about your medical status.

***I authorize the following person(s) to communicate with your office regarding my care:**

Name/Relationship: _____ Phone Number: _____ Your Initial _____

Name/Relationship: _____ Phone Number: _____ Your Initial: _____

