GLENWOOD
FAMILY EYE CENTER
GLACIAL RIDGE HEALTH SYSTEM

PATIENT REGISTRATION FORM

Demographic Information

Patient Name: _____ **Date of Birth:**_____
Last First Middle Initial

Address:_____

City:_____ **State:**_____ **Zip Code:**_____ **Gender: Male / Female**

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Patient Social Security Number: _____

Employer: _____ Employment Status:_____

Contact Information

Contact Person:_____ Relationship: _____

Contact Number (s):_____

Insurance Information

Primary Insurance: _____ ID:_____ Group:_____

Secondary Insurance: _____ ID:_____ Group:_____

Work Comp/Employer Pay/Auto Insurance: _____

_____

Contact Person for Work Comp or Employer Pay:_____

Authorizations

Authorization to pay benefits to Physician/Provider: I hereby authorize payment directly to the undersigned physician/provider of the surgical and/or medical center payments, if any, otherwise payable to me for services as described.

Signature: _____

Authorization to release information: I hereby authorize the undersigned physician/provider to release any information acquired in the course of my examination or treatment.

Signature: _____