Precision Eye Care, Inc.

Comprehensive Ophthalmology
John R. Fitz, M.D., F.A.C.S.
Anton G. Beffa, M.D., F.A.C.S.
Michael A. Morris, M.D., F.A.C.S.

PATIENT REGISTRATION

PATIENT NAME: _____ HOME PHONE: _____

MAILING ADDRESS: _____ CELL PHONE: _____

CITY: _____ STATE _____ ZIP: _____ SEX: MALE / FEMALE

DATE OF BIRTH: _____ SOCIAL SECURITY # _____ MARITAL STATUS: M / S / W / D

EMPLOYER'S NAME: _____ WORK PHONE: _____

RACE: _____ ETHNICITY: _____ LANGUAGE: _____

NAME OF SPOUSE: _____ SPOUSE'S DATE OF BIRTH: _____

SPOUSE'S EMPLOYER: _____ SPOUSE'S SSN: _____

REFERRAL DR. _____ FAMILY DR. _____

OPTOMETRIST _____

EMERGENCY CONTACT: PLEASE LIST A FRIEND OR RELATIVE WITH A PHONE NUMBER THAT LIVES OUTSIDE OF YOUR HOME:

NAME	RELATIONSHIP	CONTACT'S PHONE NUMBER

INSURANCE INFORMATION

PRIMARY INSURANCE CO.: _____

SUPPLEMENTAL INSURANCE CO.: _____

I hereby authorize Precision Eye Care, Inc. to release any information acquired in the course of my examination or treatment as required by my insurance company. I request payment of authorized benefits be made on my behalf to Precision Eye Care, Inc., for any services furnished to me by their physicians. I also understand that I am financially responsible for all charges whether or not paid by insurance, as well as any co-payments and deductibles. I realize that this may not represent the full payment for services rendered and I will be responsible for the balance due.

_____ _____

Patient Signature *Date*