JOHN-KENYON

Please Print

Patient Registration

CONFIDENTIAL

Date ____/____/____ Preferred Name _____

Name _____ Date of Birth ____/____/____ Age_____ ☐ Male ☐ Female

Preferred Language _____ Race _____ Ethnicity ☐ Hispanic or Latino / ☐ Not Hispanic or Latino

Address _____

City _____ State _____ Zip _____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

E-mail Address:_____

(This information will be kept confidential)

Who Referred You to Us ? _____ Family Eye Doctor _____

Family Doctor _____ Address _____

Pharmacy (Name and Location) _____ Phone (____) _____

Social Security No. _____ ☐ Single ☐ Married ☐ Widow ☐ Divorced

☐ Resides In A Skilled Nursing Facility

Occupation _____ Employer (☐ Present ☐ Former) _____

Spouse/Parent Name _____ Spouse/Parent Employer _____ WK Phone (____) _____

Friend/Relative (Not Living With You) _____ Phone (____) _____

Power of Attorney (If Applicable) _____ Phone (____) _____

Address _____

Insurance Information

Primary _____ Policy Holder _____ Their Date of Birth ____/____/____

Employer Plan ☐ Yes ☐ No If so, please list _____ Referral Required ☐ Yes ☐ No

Secondary _____ Policy Holder _____ Their Date of Birth ____/____/____

Employer Plan ☐ Yes ☐ No If so, please list _____ Referral Required ☐ Yes ☐ No

Drug Coverage Provider (Medicare Part D) _____ Policy Number_____

Payment is requested at time of service. We accept cash, check and all major credit cards.

Consent to Telephone calls: If at any time I provide a telephone number at which I may be contacted, I consent to receive calls or text messages including but not restricted to communications regarding billing and payment for items and services, unless I notify the office to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication from the office, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collection agencies.

Consent to email usage: If at any time I provide my email address at which I may be contacted, unless I notify the office to the contrary in writing I consent to receiving communications regarding billing and payment for items and services at that email address from the office, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collection agencies.

Signature of Patient/Responsible Party_____Date _____/_____/____