

**Registration (Please Print)**

Date \_\_\_\_\_ Soc.Sec.# \_\_\_\_\_ Sex \_\_\_\_\_

Patient's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Single  Married  Widowed  Divorced Person To Pay Account \_\_\_\_\_

Primary Insurance \_\_\_\_\_ Name of Insured \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Name of Insured \_\_\_\_\_

Employed By \_\_\_\_\_ Referred By \_\_\_\_\_

Emergency Contact Person and Phone# \_\_\_\_\_

I have read the Altos Eye Physicians Notice of Privacy Practices. I assume responsibility for my account.

Signed \_\_\_\_\_ Print Name \_\_\_\_\_

If signing as a parent or guardian, please note the name of the patient \_\_\_\_\_