

OPHTHALMIC CONSULTANTS OF LONG ISLAND: REGISTRATION FORM (PLEASE PRINT)

| PATIENT INFORMATION | | | | |
|--|--|---|---|---|
| Patient's Name (First name Middle name Last name): | | | <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Dr. | |
| Email Address: | Social Security No.: | Birth date: / / | Age: | Sex: <input type="checkbox"/> M <input type="checkbox"/> F |
| Street address: | | Home phone: () | Cell phone: () | |
| City: | | State: | Zip: | |
| Occupation: | Employer: | Employer phone: () | | |
| RESPONSIBLE PARTY INFORMATION (IF DIFFERENT THAN ABOVE) | | | | |
| Name (First name Middle name Last name): | | Social Security no.: | Birth date: / / | Sex: <input type="checkbox"/> M <input type="checkbox"/> F |
| Street address: | | City: | State: | ZIP Code: |
| Relationship to Patient: | | Home phone: () | Cell phone: () | |
| INSURANCE INFORMATION | | | | |
| Name of PRIMARY Insurance & ID#: | | Name of SECONDARY Insurance & ID#: | | |
| PRIMARY CARE PHYSICIAN (PCP) | | | | |
| Name: | | Address: | | Phone: () |
| OPTOMETRIST (OD) | | | | |
| Name: | | Address: | | Phone: () |
| REFERRING DOCTOR (OTHER THAN PRIMARY CARE PHYSICIAN & OPTOMETRIST) | | | | |
| Name: | | Address: | | Phone no: () |
| IN CASE OF EMERGENCY | | | | |
| Emergency Contact (Not living at same address): | | Relationship: | Home phone: () | Work phone: () |
| ARE YOU INTERESTED IN? (PLEASE CHECK ALL APPROPRIATE BOXES) | | | | |
| <input type="checkbox"/> Decreasing Your Need for Reading Glasses | <input type="checkbox"/> LASIK | <input type="checkbox"/> Cosmetic Options: Botox, Dermal Fillers, Eyelid Lifts, Etc | | |
| HOW DID YOU HEAR ABOUT OCLI? (please check ALL appropriate boxes): | | | | |
| <input type="checkbox"/> Family/Friend (please specify person) | <input type="checkbox"/> Dr. (please specify doctor) | <input type="checkbox"/> Website (please specify site) | <input type="checkbox"/> Insurance Plan | |
| <input type="checkbox"/> Radio (please specify radio station) | <input type="checkbox"/> Newspaper Ad (please specify paper) | <input type="checkbox"/> Yellow Pages | <input type="checkbox"/> Other (please specify other) | |
| PHARMACY | | | | |
| Name: | | | | |
| Address: | | City: | State: | Zip: |

Patient Signature: _____ Date: _____