

**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: \_\_\_\_\_