Reveal Eye Care & Surgery 3613 Williams Dr, Suite 703, Georgetown, TX 78628 Ph: (512) 686-1224 Fax: (512) 686-1272

PATIENT REGISTRATION FORM v1.06

How did you hear about us?:_____

Primary Care Doctor:_____ **Fax:** _____

Eye Doctor:_____ **Fax:** _____

Patient Name._____
Last First Middle

Date of Birth_____ Age _____ Gender M F SSN _____

Cell Phone_____ Email _____

Home Phone_____Marital Status Single Married Divorced Widowed

Work Phone_____ Preferred Method of Communication _____

Home Address_____

City_____State_____ Zip Code_____

Occupation_____ Spouse's occupation _____

Spouse name (Parent if minor)_____Spouse Phone_____

Person to notify in case of emergency (other than spouse)_____

Phone number(s)_____Relationship_____

Preferred Pharmacy Name & Phone number_____

☐ Check if Patient and Subscriber are the same

Subscriber Name_____
Last First Middle

Subscriber Date of Birth_____ Subscriber Relationship to Patient _____

☐ Check if address the same as patient

Subscriber Address _____

Are we able to leave messages with health information on your voicemail or answering machine? **YES** or **NO**

Are we able to leave email messages with health information on your listed email? **YES or NO**

Are we able to use automated patient reminders such as text messages and automated voice reminders? **YES** or **NO**

Please list individuals that can receive your health information: _____

I certify that the above information is true to the best of my knowledge, and I acknowledge that I have read and agreed to the financial policy that I received. I also understand that my eyes may need to be numbed and dilated to diagnose my condition, and that this may result in blurry vision for several hours. I understand that it would be best to arrange a driver until I know how these drops affect me.

_____ _____

Patient's signature **Today's date**