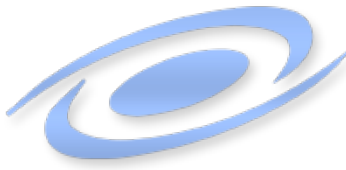


**LASIK CENTER OF STATEN ISLAND
NEW DORP EYE SPECIALISTS**
445 CLAWSON STREET
STATEN ISLAND, NY 10306
718-351-0525



VICTORY EYE SPECIALISTS

3860 VICTORY BLVD
STATEN ISLAND, NY 10312
718-370-2222

REGISTRATION FORM

(Please Print)

Today's date:							
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Street address:			Social Security no.:		Home phone no.: ()		
P.O. box:	City:		State:		ZIP Code:		
Email:		Alternate Phone Number: ()			Pharmacy Phone Number: ()		
Chose clinic because/Referred to clinic by (please check one box):				<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Online	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other			
Other family members seen here:							

INSURANCE INFORMATION						
(Please give your insurance card to the receptionist.)						
Person responsible for bill:		Birth date: / /	Address (if different):		Home phone no.: ()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Occupation:	Employer:	Employer address:			Employer phone no.: ()	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Please indicate primary insurance:						
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: \$
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other						
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other						

IN CASE OF EMERGENCY				
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: ()	Work phone no.: ()

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Victory / New Dorp Eye Specialist / LASIK Center of Staten Island or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date