Patient Registration – Insurance Covered

Name: ____ Today's Date: ______________
Last First MI Preferred Name Month/Day/Year

Address: ____
Street City State Zip Code

Home Phone: ________________ Work Phone: __________________ Cell phone: ______________

Email: _________________ @_____________ ._____ Social Security Number : ________ - ____ - ________

Age: ________ Date of Birth: ______________ Sex: M F Marital Status: S M W D
Month/Day/Year

Spouse or Parent's Name:_________________ Spouse's DOB: __________ Tel #: _______________
Last First Month/Day/Year

Emergency contact not living with you: ________________________ Relationship: ______________

Address: ____ Telephone: ______________

What is the name of your primary care physician? _____________________ Telephone: ______________

What is the name of your current optometrist? _______________________ Telephone: ______________

Whom may we thank for this referral? ____

Pharmacy Name: __________________ Telephone: ______________

Have you had a recent hospitalization that caused you to spend time in any form of skilled nursing facility? ☐ Y ☐ N

Are you currently residing in a nursing home/facilty? ☐ Y ☐ N

Preferred method of contact: ☐ Home ☐Cell ☐Email May we leave a message on voice mail/answering machine? Y N

Health Insurance Information

Do you have health insurance? Yes No Medicare? Yes No **Your Medicare Number:** ______________

If not Medicare, what is the name of your primary medical insurance? ________________________

Is the policy holder the above patient? ☐ Y ☐ N If **no**, policy holder's information must be completed below.

Policy holder name: ______________________ Relationship: ______________________

Address: ____ Telephone: ______________

Date of Birth: _________________________

Do you have secondary medical insurance? Y N Secondary Insurance Name: ______________________

Please complete both sides of this form. Thank you.

For billing purposes, our receptionist will make a copy of your insurance plan cards.

Patient name_____________________________ Date_____________________________________

These questions are about your race, ethnicity, and primary language. We ask these questions to make sure we are meeting the needs of all of our patients.

Disclosure of below information is completely voluntary.

1. Are you of Hispanic or Latino origin?

☐ Yes
☐ No
☐ Decline
☐ Don't Know

2. Which of the following best describes your race? If necessary, you may select up to two.

☐ Black
☐ White
☐ Asian
☐ American Indian/Alaska Native
☐ Native Hawaiian/Pacific Islander
☐ Decline
☐ Don't Know
☐ Other

3. Please provide <u>one</u> nationality or ethnic group that best describes your ancestry. *(For example, Italian, Jamaican, African American, Haitian, Korean, Lebanese, etc.)*

☐ African American
☐ Albanian
☐ Belgian
☐ Bangladeshi
☐ Chaldean
☐ Chinese
☐ Chippewa/Ojibwe
☐ Cuban
☐ Czechoslovakian
☐ Dutch
☐ Egyptian
☐ English
☐ Filipino
☐ Finnish
☐ French
☐ German
☐ Greek
☐ Haitian
☐ Hawaiian
☐ Huron
☐ Indian (Not Native Amer)
☐ Iranian
☐ Iraqi Indian (East Asian)
☐ Irish
☐ Italian
☐ Jamaican
☐ Japanese
☐ Jordanian
☐ Korean
☐ Lebanese
☐ Macedonian
☐ Mexican
☐ Nigerian
☐ Ottawa/Odawa
☐ Palestinian
☐ Persian
☐ Polish
☐ Potawatomi
☐ Puerto Rican
☐ Romanian
☐ Russian
☐ Scottish
☐ Spanish (Spain)
☐ Syrian
☐ Ukrainian
☐ Vietnamese
☐ Decline
☐ Don't Know
☐ Other (specify)________________

4. How would you rate your ability to speak English?

☐ Very well
☐ Well
☐ Not well
☐ Not at all
☐ Decline
☐ Don't Know

5. What language do you feel most comfortable using when discussing your health care?

☐ American Sign Language
☐ Albanian
☐ Arabic
☐ Bengali
☐ Cantonese
☐ English
☐ Italian
☐ Mandarin
☐ Russian
☐ Spanish
☐ Vietnamese
☐ Yemen Arabic
☐ Decline
☐ Don't know
☐ Other (specify)________________

Thank you. Please return this form to the front desk staff person WEI representative.

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