

**Milliken Eye Care**7 New Driftway  
Scituate, Ma 02066**PATIENT REGISTRATION FORM**

(Please Print)

PCP:				Today's date:			
<b>PATIENT INFORMATION</b>							
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?		How do you prefer to be addressed?		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:	
Occupation:		Employer:			Employer phone no.: (    )		
How did you hear about us? (please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Current Patient		<input type="checkbox"/> Phone Book	<input type="checkbox"/> Other		
Other family members seen here:							
E-mail address:							
<b>INSURANCE INFORMATION</b>							
(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							
Please indicate primary insurance		<input type="checkbox"/> BlueCross/Blue Shield		<input type="checkbox"/> Cigna		<input type="checkbox"/> Davis Vision	<input type="checkbox"/> Harvard Pilgrim
<input type="checkbox"/> Neighborhood	<input type="checkbox"/> Medicare		<input type="checkbox"/> Tufts	<input type="checkbox"/> VSP		<input type="checkbox"/> Other	
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		
<b>IN CASE OF EMERGENCY</b>							
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 Milliken Eye Care or insurance company to release any information required to process my claims.							
_____ <i>Patient/Guardian signature</i>						_____ <i>Date</i>	