Progressive Vision Group, P.A.

Joseph N. Perez, Jr., O.D. Staci A. Palmer, O.D.

Patient Registration Form

Please complete this form and return it to our receptionist. The following information will not be released unless you have authorized us to do so.

Patient Information **Today's Date: ________________________**

Last Name___________________________First Name___________________M.I._____Suffix__

Preferred Name______________________Maiden Name_______________________________

Street Address______________________________City_______________State____Zip_______

Date of Birth_____/_____/______Sex__________Race____________

Marital Status______________ Last 4 of SSN___________

Preferred Phone Number________________Alternate Phone Number_____________________

Email____

Employment Status *(Circle)* Full Time Part Time Student Full/Part Retired

Employer/School____

Responsible Party *(Complete ONLY if different from above information)*

Last Name___________________________First Name______________________M.I.________

Street Address______________________________City_______________State____Zip_______

Phone___________________Alternate_______________________Relationship_____________

Date of Birth____/____/______ Last 4 of SSN___________________

Emergency Contact *(Complete if different from responsible party)*

Last Name____________________________First Name _____________________M.I.________

Relationship to Patient _________Preferred Phone______________Alternate_______________

Insurance Information *(Please bring insurance cards to appointment)*

Primary Insurance:____

Policy Holder_____________________________Policy Holder's Date of Birth____/____/______

Secondary Insurance *(If applicable)*:____

Policy Holder_____________________________Policy Holder's Date of Birth____/____/______