

**Rock Hill Eye Center  
Patient Registration Form**

**PATIENT INFORMATION (Please print)**

Chart #: \_\_\_\_\_

Full Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex:  M  F E-mail Add.: \_\_\_\_\_

Address \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

Is the Name of the Insured the same as the Patient?  Y  N If no, please fill out  
Responsible Party Information Below:

Full Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex:  M  F

Address \_\_\_\_\_

Home Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

**INSURANCE INFORMATION**

**VISION COVERAGE: Do You Have a Vision Plan?**  Y  N If so, what is  
the name of your Vision Insurance? \_\_\_\_\_ ID#: \_\_\_\_\_.  
(Often, your vision insurance will be with a different company than your medical coverage)

**Primary Medical Insurance: Name of Insurance:** \_\_\_\_\_

ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ DOB \_\_\_\_\_

Employer: \_\_\_\_\_ SSN: \_\_\_\_\_

**Secondary Medical Insurance: : Name of Insurance:** \_\_\_\_\_

ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ DOB \_\_\_\_\_

Employer: \_\_\_\_\_ SSN: \_\_\_\_\_

**IS THIS VISIT WORK RELATED?**  Y  N If yes, please describe: \_\_\_\_\_

**CONSENT TO TREATMENT, ASSIGNMENT, AND RELEASE**

I hereby consent to the treatment for myself or the patient listed on this form. I hereby certify that I assign all insurance benefits directly to the Rock Hill Eye Center and I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. This authorization shall remain valid, until written notice is given by me, revoking said authorization.

Signature of Patient/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_