PATIENT REGISTRATION

Please complete/circle/mark answers as appropriate

About Eyes, Inc.
Dr. Leslie R. Dullnig

Last Name: _____ First Name: _____ MI: _____ Mr. Dr. Mrs. Ms Miss

Is the Patient also the Responsible Party/Guarantor: Yes No If No, Please complete the following information:

Resp. Party Last Name: _____ First Name: _____ MI: _____ Relationship:_____

Address _____ Address 2: _____

City: _____ ST: _____ Zip: _____ Home Phone: _____

Cell Phone: _____Work Phone: _____ Ext: _____ Email _____

Patient Address: _____ Birth Date: _____ Gender M F

Patient Address 2: _____ SS# _____

City: _____ STATE: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext: ____

Office: □ San Marcos □ Blanco Patient's Email:_____

Referred By: Friend Relative Who?: _____ Are they one of our Patients: Y N

□ Saw our Sign □ Insurance Provider List □ Internet □ Google □ Yellow Pages (which one?) _____

□ Other: _____ May we contact you by email? □ Yes □ No By text? □ Yes □ No

* If married, Spouse's Name: _____ YOUR Preferred Name: _____

Marital Status : □ Married □ Single □ Divorced □ Widowed □ Separated

Emergency Contact: □ Same as Responsible Party/Guarantor If not, Please complete the following information:

Emerg Contact Name: _____ Contact Phone: _____Relationship _____

Primary Insurance Company: _____ ID: _____ Group: _____

Insured Last Name: _____ First Name: _____ Date of Birth: _____

What is the relationship of the patient to the Insured: □ Spouse □ Child □ Other Dependent

Secondary Insurance Company: _____ ID: _____ Group: _____

Insured Last Name: _____ First Name: _____ Date of Birth: _____

What is the relationship of the patient to the Insured: □ Spouse □ Child □ Other Dependent

Your Employer: _____ □ Full Time □ Part Time □ Self □ Retired □ Not Employed

Your Occupation: _____ Student: □ Full Time □ Part Time Grade: _____

What is your Ethnicity: (mark one) □ Hispanic or Latino □ Not Hispanic or Latino

Race: (mark one) □ American Indian or Alaskan Native □ Asian □ Native Hawaiian or Other Pacific Islander

□ Black or African American □ White □ Hispanic □ Not Specified □ Other

What is your preferred language? □ English □ Spanish □ Other: _____

Smoking Status: □ Current every day smoker □ Current some day smoker □ Former smoker □ Never Smoked

Patient's sex: □ Female □ Male

Preferred Communication Method □E-mail □ Letter □Phone I want to receive correspondence via e-mail □ Y □ N

Dr. Dullnig recommends a dilated eye health exam. Please INITIAL one: I would like to: ____Dilate today ____Dilate another day ___No dilation