Date: _____
Gender: ☐ M / ☐ F
☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms.

CLARITY EYE CENTER
personalized eye care

Registration Form

Patient Name_____Date of birth____/_____/_____
First name Middle Initial Last name

Mailing Address _____ City _____State_____ Zip_____

Street Address (if different from above) _____

Home Phone # Only _____ Cell Phone # Only _____

Email _____ Language Preference_____

Driver's License # _____ Social Security # _____

Employer _____ Work Phone # _____

Occupation _____ Ethnicity: Check one ☐ Hispanic ☐ Non-Hispanic

Race: Check one ☐ White ☐ Black ☐ Asian ☐ Native Hawaiian ☐ American Indian/ Native Alaskan

Marital Status: Check one ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Emergency Contact: Relative or Friend not living with you for messages in case we are unable to reach you.

Name _____Relationship _____ Phone _____

****** Preferred Method of contact for appointment reminders******
Please choose ONLY one option below

☐ Text Message ☐ Voice Call: Check one ☐ Home/ ☐ Cell ☐ Email

☐ **Spouse** ☐ **Parent** ☐ **Guardian Information (Please choose one)**

Name _____ Date of birth _____/_____/_____
First name Middle Initial Last name

Address (if different) _____

Home phone _____Work phone _____ SS # _____

Employer _____ Occupation _____

Primary Insurance Company

Insurance	ID number	Group Number
Name of policy Holder	SS#	**Subscriber's DOB**

Secondary Insurance Company

Insurance	ID number	Group Number
Name of policy Holder	SS#	**Subscriber's DOB**

******** WE WILL COPY YOUR INSURANCE CARDS AND DRIVERS LICENSE AT THE TIME OF YOUR VISIT ********