EDINA EYE
A DIVISION OF TWIN CITIES EYE CONSULTANTS

PATIENT REGISTRATION FORM

Today's date:				
PATIENT INFORMATION				
Patient name: First, M.I., Last				Date of birth:
Address: Street	City	ST	Zip	
Social Security #:	Cell phone:			Home phone:
Email:				Sex: F M
Primary doctor: Name	Clinic			
Referring doctor: Name	Clinic			
GUARANTOR INFORMATION				
Name:				Date of birth:
Address: Street	City	ST	Zip	
Phone:	SS#:			Relation:
INTERPRETER				
Do you need an interpreter? Y N	Specify language here			
How did you hear about us? Please circle				
TV Radio Internet Physician Relative Friend Insurance Other				
INSURANCE INFORMATION				
Primary insurance:			Secondary insurance:	
Name of insurance			Name of insurance	
Subscriber name:	Date of birth:		Subscriber name:	Date of birth:
SS#:	Relation:		SS#:	Relation:
Vision plan:	Subscriber:		SS#:	Relation:
Name of plan				
IN CASE OF EMERCENCY				
Name:	Relation:		Phone:	
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 Edina Eye Physicians and Surgeons to release any information required to process my claims.				
Patient /Guardian signature			Date	