

**RASHID & RICE EYE ASSOCIATES, PLLC
REGISTRATION FORM - Please Print**

PATIENT INFORMATION:

DATE: _____

NAME: _____
(First) (Middle) (Last)

Street Address: _____

City, State, Zip: _____ Drivers License# _____

Social Security#: _____ Date of Birth: _____ Age: _____

Sex: M _____ F _____ Home Phone: _____ Work Phone: _____

Marital Status: M _____ S _____ W _____ Email: _____ Cell Phone: _____

Pharmacy for Prescriptions _____

Emergency Contact: Name _____ Phone : _____

Employer Name: _____

Employer Address: _____

Spouse Name: _____

Spouse Employer: _____

INSURANCE INFORMATION:

Primary Insurance: _____ Policy #: _____

***Policyholder: _____ Date of birth of policyholder if different from insured _____

Secondary Insurance: _____ Policy #: _____

***Policyholder: _____ Date of birth of policyholder if different from insured _____

ALL AMOUNTS DUE THAT ARE NOT COVERED BY INSURANCE WILL BE COLLECTED AT TIME OF APPOINTMENT

NAME OF YOUR PRIMARY CARE PHYSICIAN: _____

List any known allergies: _____

Are you a resident of a skilled nursing Facility? _____ . If yes - Name of Facility _____

IF PATIENT IS UNDER 18, LEGAL GUARDIAN TO COMPLETE #s 1-7 BELOW

1.) Name: _____
(First) (Middle) (Last)

2.) Relationship to Patient: _____

3.) Address: _____

4.) Social Security: _____ Date of Birth: _____

5.) Employer Name; _____

6.) Employer Address: _____

7.) Employer Phone #: _____

Notice:

1. The Physician/Owners of this practice also own Mockingbird Optical Shop San Antonio TX.
2. The Physician/Owners of this practice also own a partial interest in Specialty Surgery Center, San Antonio, TX.

