# PATIENT REGISTRATION

**Valley Eye & Laser Center** 4011 Talbot Road S. Suite 210 Renton, WA 98055 (425) 255-4250

Paul N. Joos, M.D. Chris Monson, M.D. Zachary P. Joos, M.D

**If your insurance card indicates a primary care physician (PCP) or requires a referral to see a specialist, it is your responsibility to obtain and bring a referral to your appointment. If you do not bring in a referral when required, we reserve the right to reschedule your appointment.**

Patient name: ______________________ Birthdate: ______________

Sex: M F (circle) Marital Status: S M W D Child (circle) Language: ______________

Race: ____________ ☐ Decline to Answer Ethnic Group: ____________ ☐ Decline to Answer

Address: ______________________ City: ______________ State: ______ Zip: ______

Preferred Phone: (____) __________ Home Phone: (____) __________ Cell Phone: (____) __________

Ok to receive text messages for appointment reminders? *(circle one)* YES NO

Email: ______________________________________________

Work Phone #: (____) __________ Employer: ______________________

Primary Care Physician: ______________________ Phone: (____) __________

Preferred Pharmacy: ______________________ Phone: (____) __________

Emergency Contact: ______________ Relation: __________ Phone: (____) __________

Who may we thank for referring you to our office? ______________________

**If patient is a child, you must complete the following:**

Father: ______________________ Birthdate: ______________

Address: ______________________ City: ______________ State: ______ Zip: ______

Home Phone: (____) ______________ Work Phone: (____) ______________

Employer: ______________________ Occupation: ______________

Mother: ______________________ Birthdate: ______________

Address: ______________________ City: ______________ State: ______ Zip: ______

Home Phone: (____) ______________ Work Phone: (____) ______________

Employer: ______________________ Occupation: ______________

**CONTINUED ON OTHER SIDE**

**IF YOU DID NOT PRESENT YOUR INSURANCE CARD PLEASE PROVIDE INSURANCE INFORMATION: Please fill out completely**

**PRIMARY MEDICAL:**

Insurance Company Name: ______________________________

Subscriber's Name: ______________________ Birthdate: ____________

SSN or Identification Number: ________________ Group Number: ____________

Employer: ________________ Relationship to Patient: ________________

Amount of Co-Payment: $________

**SECONDARY MEDICAL:**

Insurance Company Name: ______________________________

Subscriber's Name: ______________________ Birthdate: ____________

SSN or Identification Number: ________________ Group Number: ____________

Employer: ________________ Relationship to Patient: ________________

Amount of Co-Payment: $________

**IF YOU HAVE SEPARATE VISION INSURANCE, PLEASE PROVIDE CARD OR INFORMATION TO RECEPTIONIST.**

**VISION INSURANCE:**

Insurance Company Name: ______________________________

Subscriber's Name: ______________________ Birthdate: ____________

SSN or Identification Number: ________________ Group Number: ____________

Employer: ________________ Relationship to Patient: ________________

Amount of Co-Payment: $________

**If work related injury, Please complete the following information if you did not bring your claim form:**

Labor and Industries Claim Number: __________ or Self Insured Claim Number: ____________

Date of Injury: __________ Employer when injured: ____________ Phone: (____) __________

City where injury occurred: ________________ Cause of injury: ________________

Valley Eye & Laser Center keeps a record of the health care services we provide to you. You may ask us to see and copy that record. Valley Eye & Laser Center will not disclose your records to others unless you direct us to do so in writing or unless the law authorizes or compels us to do so. Copies of "Patient's Rights" are available from the receptionist. The above information is true to the best of my knowledge. I understand I am responsible for charges associated with medical or vision services and agree to pay all bills within 30 days of receipt of statement, unless other arrangements are made. I authorize the physician (Center) to release any information to process insurance claims. I authorize the insurance to be paid directly to the physician (Center). I also authorize you to give me reasonable and proper medical care by today's standards.

**PATIENT/ AUTHORIZED SIGNATURE:** ______________________ **DATE:** __________

**THERE WILL BE A $20.00 CHARGE ON ALL RETURNED CHECKS**