Eyes in Disguise Optometry
Michelle C Blas, OD

Patient Registration Form

_________________________ _________________________ _________________________
First Name Last Name Preferred Name

____
Street Address City State Zip

______________ ______________ ______________________________ Gender ☐ Male ☐Female
Last 4 digits of SSN Date of Birth Email address

______________________ ______________________ ______________________
Cell phone Work phone Home phone

VISION INSURANCE INFORMATION
☐ EyeMed ☐ VSP ☐ Medical Eye Services ☐ Other ___________________________

PRIMARY MEDICAL INSURANCE INFORMATION

____
Name and Address of Primary Insurance Company City State Zip

____
Insured's First Name Insured's Last Name Group # Policy #

Patient Relationship to Insured
☐ Self ☐ Spouse ☐Child ☐Other

Patient Status ☐Single ☐Married ☐ Other
☐FT student ☐ PT student ☐Employed

SECONDARY MEDICAL INSURANCE INFORMATION

____
Name and Address of Secondary Insurance Company City State Zip

Medical Doctor: _________________________________ **Last Eye Exam:** ___________________

Emergency Contact: ____

Patient Communications: How do you prefer to receive information regarding appointments and services at Eyes in Disguise Optometry? ☐Email ☐ Text ☐ Phone

Patient Portal: Are you interested in participating in our online patient portal to have access to your health information at Eyes in Disguise Optometry? ☐ Yes, tell me more ☐ No