NewView EYE CENTER & ANTI-AGING
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Jacqueline D. Griffiths, M.D., P.C.

Patient Registration

Date___/____/_______

Name __________________________ ____________________________ ___ **DOB** ___/___/______ **Age**____
Last First MI

Address____ ______________________ _____ ____________
Street City State Zip

Phone: (Home) ____-____-_______ (Work) ____-____-_______ (Cell) ____-____-_______ SS#: ____-___-____

Employer: ________________________ Occupation: ___________________ Marital Status: S/M/D/W

Gender: M/F Emergency Contact __________________________________ Phone _____-_____-_______

Email: ____ Referred By: __________________________________

Do you have a Flexible Benefits Plan? ☐ Yes ☐ No

(If patient is a child or <u>COLLEGE STUDENT</u> please complete this section)

Parent/Guardian_____________________ _______________________ ___ **DOB** ___/___/______ **Age**____
Last First MI

Address____ ______________________ _____ ____________
Street City State Zip

Home ______-______-________ Work ______-______-________ SSN: _______-____-_______

Employer_________________________________ Child's School or University___________________________

Insurance Information (Please give your insurance card to the receptionists with this form)

Primary_______________________________________ Effective Date _____/_____/_______

Address____ Phone _____-_____-_______

ID# _______________________________ Group/Plan _____________________ SSN ____-___-_____

Policy Holder's Name _______________________________ **DOB** ___/___/______ **Age**____

Employer ____

Patient's Relationship to Policy Holder: Self / Spouse / Child / Other: ______________________

Secondary_______________________________________ Effective Date _____/_____/_______

Address_______________________________ Phone _____-_____-_______

ID# _______________________________ Group/Plan _______________________________

Policy Holder's Name _____________________________ SSN ___-___-_____ **DOB** ___/___/______ **Age**____

Employer ____

Patient's Relationship to Policy Holder: Self / Spouse / Child / Other:_______________________