Campus Eye Center
2108 Harrisburg Pike
Suite 100
Lancaster, PA 17601-2644
Phone (717)974-9661
Fax (717)974-9669

Patient Registration

Please review, make necessary changes and supply any missing information.

Patient Name				Salutation	
Date of Birth		Age		Nickname	
Sex				SS #	
Address					
Address Type				Country	

Communication					
Preference					
Home Phone #		Work Phone #		Extension	
Cell Phone #		Cell Phone Carrier			
Email					

Information			
Plan Type		HIPAA Signed	
Primary Language		Special Needs	
Race		Ethnicity	
Marital Status		Mother's Maiden Name	
Family Doctor		Employer	
Occupation		Employer Address	

Account Responsible					
Responsible				Acct Resp Date of Birth	
Relationship				SS #	
Address					
Home Phone #		Work Phone #		Extension	
Email					
Last Payment			Last Statement		

Primary Insurance			
Name		Group Name	
ID #		Group #	
Address			
Phone		PAY %	

Primary Insurance			
Insured		Insured Date of Birth	
Copay			

Secondary Insurance			
Name		Group Name	
ID #		Group #	
Address			
Phone		PAY %	
Insured		Date of Birth	

Emergency Contact										
Sal	First	M	Last	Relation	Home#	Cell#	Work#	Ext	Organization	Title

Other Contacts										
Sal	First	M	Last	Relation	Home#	Cell#	Work#	Ext	Organization	Title

Release Of Medical Information		
Name	Relation	Release Status

I consent to the disclosure of my protected health information to the above named individuals.

Patient Name:_____ Patient Signature_____
(or legal guardian)