

The Office of Stephen E. Webb, M.D.

Surgical, Medical and Refractive Ophthalmology

PATIENT REGISTRATION / PLEASE PRINT

Patient Name: _____ , _____
Last Name First Name M.I.

Patient's Date of Birth: ____ / ____ / ____
Month Day Year

Address: _____ **City/State:** _____ **Zip:** _____

Home Phone: (____) ____ - ____ **Work or Cell Phone:** (____) ____ - ____

Male: ____ **Female:** ____ **Circle One:** **Single** **Married** **Widowed** **Divorced**

Patient's Social Security Number or other ID#: ____ - ____ - ____

Name of Spouse or Parent/Guardian (if applicable): _____

Patient's Employer and Phone #: _____

Referred by (full name, please): _____

Has anyone in your family seen us before? _____

MEDICARE INSURANCE INFORMATION (IF APPLICABLE for those 65 years and older):

Medicare #: _____ (must end in a letter)

Name of Secondary Insurance if applicable: _____ **Policy/Group:** _____

Name and ID of insured for Secondary if not self: _____

REGULAR / PRIVATE INSURANCE INFORMATION:

Name of Insurance Co: _____ **Policy/Group:** _____

Phone Number of Insurance: (____) ____ - ____

