ADELSON
EYE & LASER CENTER

Dr. Howard Adelson, D.O., FAOCO
Dr. Todd Adelson, D.O

PATIENT REGISTRATION

Last Name ______________________________ First Name ______________________________ Initial ___

Address ___________________________________ City/State/Zip _________________________________

Home/Cell Phone __________________ Work Phone _________________ Email ____________________

Date of Birth _________________ Social Security # _____________________ Male I Female

Employer ____________________________________ Occupation _________________________________

Emergency Contact ___________________ Phone # _________________ Relationship _______________

How did you hear about our office? ____

Primary Care Physician _____________________________________ Phone # ______________________

Optometrist ____ Phone # ______________________

INSURANCE INFORMATION

Medical Primary Insurance ____

Policy Holder Name ___________________________________ Policy Holder Date of Birth ______________

Policy ID ____________________________ Group _____________________ Member _________________

Secondary Insurance ____

Policy Holder Name ___________________________________ Policy Holder Date of Birth ______________

Policy ID ____________________________ Group _____________________ Member _________________

I authorize the release of any information necessary, including my medical record, to process any insurance claim.

____ ______________
Patient Signature (or person authorized) Date