E. Watts Davis, OD
Evan W. Davis, OD

Eye Care Associates

Stephen Mitchell, OD

1431 West 10th Street
Laurel, MS 39440
Phone: 601-649-1437
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825 Jefferson Street
Monticello, MS 39654
Phone: 601-587-2452
Fax: 601-587-9457

519 Mississippi Dr.
Waynesboro, MS 39367
Phone: 601-735-2878
Fax: 601-735-2879

REGISTRATION SHEET

Patient Information

Name: _____ (Last) _____ (First) _____ (Middle Initial) -- -- (Social Security#)

Address: _____ (Street) _____ (Apt#) _____ (City) _____ (State) _____ (Zip)

Phone: _____ (Home) _____ (Cell) _____ (Work) _____ (Email)
(please circle preferred number)

DOB: _____ Sex: Male Female *(circle one)* Marital Status: Single Married Divorced Separated Widowed *(circle one)*

Preferred Language: _____ Race: Native American Asian African American Caucasian (white) Other *(circle one)*

Preferred Pharmacy: _____ Ethnicity: Hispanic / Latino Non-Hispanic / Latino *(circle one)*

Employer Information

Employer Name: _____ Phone: _____ *Ext.*

Address: _____ (Street) _____ (Ste#) _____ (City) _____ (State) _____ (Zip)

Insurance Information *(Primary)*

Insurance Company: _____

Insured's Name: _____ (Last) _____ (First) _____ (MI) _____ (DOB) -- -- (Social Security#)

Address: _____ (Street) _____ (Ste#) _____ (City) _____ (State) _____ (Zip)

Patient's Relationship to Insured: Self Child Spouse Other (list) _____ *(circle one)*

Policy # / Member ID: _____ Group #: _____

Insurance Information *(Secondary)*

Insurance Company: _____

Insured's Name: _____ (Last) _____ (First) _____ (MI) _____ (DOB) -- -- (Social Security#)

Address: _____ (Street) _____ (Ste#) _____ (City) _____ (State) _____ (Zip)

Patient's Relationship to Insured: Self Child Spouse Other (list) _____ *(circle one)*

Policy # / Member ID: _____ Group #: _____

Responsible Party Information *(if patient is under age 18, parent or guardian completing registration sheet)*

Name: _____ (Last) _____ (First) _____ (Middle Initial) -- -- (Social Security#)

Address: _____ (Street) _____ (Apt#) _____ (City) _____ (State) _____ (Zip)

DOB: _____ Phone #: _____ Relationship: Parent Guardian *(circle one)*

Referral Information

Referred By: _____ Family Doctor: _____