FRENCH EYE CARE CENTER PLLC

P.O. Box 852
103 Roosevelt Blvd., Suite C
Eleanor, WV 25070

Patient Registration Sheet:

Legal Name _____
Last Name First Name Middle Initial

Salutation_____

Preferred Name _____

Mailing Address_____

City_____State_____Zip_____

Physical Address_____

Email Address_____

Male Female (circle one)

Social Security #_____Date of Birth_____

Home Phone Number _____

Cell Phone Number _____

Work Phone Number _____ Extension _____

Best number to contact you between 9:00 am & 5:00 pm M-F _____

In case of an emergency please contact _____

Phone number _____ Ext. _____Relationship _____

I have read and signed the **Financial Agreement** provided stating I agree with the financial policies of French Eye Care Center, PLLC.

Signed by _____Date ___ / ___ / ___
Patient / Parent / Guardian / Medical Power of Attorney