THE SELEM CENTER
OPHTHALMOLOGY & PLASTIC SURGERY

MIAMI eye CENTER

Joseph Selem, M.D.

PATIENT REGISTRATION

Patient Name | Today's Date | Date of Birth | Sex | Age

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Parent if Patient is a Minor | Email Address

Patient's Social Security Number | Florida Driver's License No.

Home Address | City | State | Zip

Mailing Address if Different | City | State | Zip

Home Telephone Number | Work Telephone Number | Cell Number

Occupation | Employer's Name

Employer's Address | City | State | Zip

Spouse Name | Employer

Primary Physician's Name | Phone Number

Reason For Visit | Whom May We Thank for Referring You to Our Practice?

NOTIFY IN CASE OF EMERGENCY

Name | Relationship

Address | City | State | Zip

Home Telephone | Work Telephone

Nearest Relative (not living with you)

Home Telephone | Work Telephone

FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR FEES

Primary Insurance

Subscriber's Name | Subscriber's Relationship ☐ Self ☐ Parent ☐ Child | Subscriber's Insurance Type

Insurance ID No.: | Group Number

Secondary Insurance

Subscriber's Name | Subscriber's Relationship ☐ Self ☐ Parent ☐ Child | Subscriber's Insurance Type

Insurance ID No.: | Group Number

Were You Injured on the Job? YES NO | Have you Informed Your Employer? YES NO

Date of Original Injury:

Worker's Compensation Carrier Name | Address

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