

**WELCOME TO THE OFFICE OF  
DR. EDMUNDO C. FIMBRES**

**PATIENT REGISTRATION**

Date \_\_\_\_\_ Circle one : Mr., Mrs. , Ms., Miss. , Child or other

Name \_\_\_\_\_ Name used/ nickname \_\_\_\_\_  
(last) (first) (m.i.)

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_

Birthday \_\_\_ / \_\_\_ / \_\_\_ Age \_\_\_ SSN \_\_\_\_\_

DriversLic# \_\_\_\_\_

Name and address of responsible party: \_\_\_\_\_  
(If different from above)

Occupation \_\_\_\_\_ Employed by \_\_\_\_\_

Date of last eye exam? \_\_\_\_\_ Name of Dr. \_\_\_\_\_

Referred By \_\_\_\_\_ Phone Ad \_\_\_\_\_ Mailer \_\_\_\_\_ Newspaper Ad \_\_\_\_\_

**MAJOR REASON(S) FOR THIS VISIT** \_\_\_\_\_  
\_\_\_\_\_

List any family members living at home:

Name	Date of Birth	Last Eye Exam
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are any family members patients here? Yes \_\_\_\_\_ No \_\_\_\_\_

Circle method of payment Cash Check Credit Other\_

**Do you have any type of vision care or major medical insurance?  
Is anyone covered under your insurance?**

Name: \_\_\_\_\_ ID#: \_\_\_\_\_  
Phone: \_\_\_\_\_

I accept responsibility for any professional or material fees not covered by my insurance company. In the event it is necessary to enforce this agreement to collect any balance due, the prevailing party shall be entitled to collect, in addition to the original amount due under this agreement, any and all collection agency fees, attorneys fees, prejudgment interest, litigation related cost , and court cost.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_