EYE CENTER on CAPITOL HILL

650 Pennsylvania Ave SE
Suite 270
Washington, DC, 20003
Tel: (202) 544-1900
Fax: (202) 547-4257
www.butruscapitoleye.com

SALIM I. BUTRUS, M.D., P.C.

PATIENT REGISTRATION FORM

(Please print clearly)

PATIENT Last Name | First Name | M.I. | Social Security # | Date of Birth

Home Address | Apt. No. | City | State | Zip Code

OCCUPATION Employer Name:

Employer Address | Apt. No. | City | State | Zip Code

Home Phone | Work Phone | Cell Phone

Preferred Contact Phone: ☐ Home ☐ Work ☐ Cel E-mail:

EMERGENCY Contact Name | Home Phone | Work Phone

FINANCIALLY RESPONSIBLE PERSON: ☐ Patient ☐ Spouse ☐ Parent ☐ Other

Financially Responsible Person's Name | Home Phone | Work Phone

Address (if different from patient's | Apt. No. | City | State | Zip Code

REFERRED BY: ☐ Physician ☐ Optometrist ☐ Optician ☐ Other

Primary Care Physician's Last Name | First Name | Office Phone

Address | Ste. No. | City | State | Zip Code

Onset of Current Problem: | Describe:

Allergies / Medications

PRIMARY INSURANCE CARRIER	**SECONDARY INSURANCE CARRIER**	**ROUTINE EYECARE (Vision) PLAN**
Insurance Name:	Insurance Name:	Insurance Name:
Address:	Address:	Address:
City, State, Zip	City, State, Zip	City, State, Zip
Telephone Number:	Telephone Number:	Telephone Number:
Subscriber Name:	Subscriber Name:	Subscriber Name:
ID Number:	ID Number:	ID Number:
Group / Plan Number:	Group / Plan Number:	Group / Plan Number: