REGISTRATION FORM.....WELCOME TO OUR OFFICE!

Please print clearly! Date_____/_____/_____

Patient's Name_____ _____
Last First MI

Patient's Date of Birth _____/_____/_____ Patient's Age_____ Sex _____Female _____ Male
Month Day Year

Parent's Name if Patient is a Minor (*under 18 yrs*)_____

Patient's School if Patient is a Minor (*under 18 yrs*)_____Grade_____

Home Address (Residence)_____Apt.#_____

City_____ State_____ Zip Code_____

Home Phone (____)_____Cell (____)_____E-mail_____

Employer_____Occupation_____

Business Address_____Business Phone (____)_____

Driver's License #_____State_____ Social Security # _____

Date of last Eye Exam_____ Previous Eye Doctor_____

Please list an emergency contact:

Name_____Phone (____)_____ Relationship_____

INSURANCE INFORMATION

1. Primary Medical Insurance: Company_____ID#_____

Subscriber's Name:_____Subscriber's DOB____/____/____ Relationship to Subscriber_____

2. Vision Care Plan: Company_____ID#_____

Subscriber's Name:_____Subscriber's DOB____/____/____ Relationship to Subscriber_____

Please show insurance cards to receptionist to be photocopied. Thank you!

ACCOUNT RESPONSIBILITY

Payment is expected when services are rendered, unless other arrangements are made in advance.

I authorize this office to release any information on this form necessary to expedite insurance claims or for inquiries from my insurance company. I understand that I am responsible for and agree to pay all charges and fees, deductibles, co-payments, co-insurance or any other balance not paid by my insurance carrier. Also, I directly assign all applicable medical/insurance/eyecare benefits to this office and understand that I am financially responsible for all charges regardless of insurance coverage or payment.

This account will be paid today by: ☐ ***Cash*** ☐ ***Check*** ☐ ***Credit/Debit Card***

Signature_____Date_____