

Client Registration Form

Date _____

Registration Information

Welcome to our office! Thank you for choosing our office for your eye care services. Please take the time to complete this questionnaire accurately and completely. It helps us do the best job possible for you. This information is held in complete confidence as it is part of your permanent record, and will not be released to anyone unless you authorize its release in writing.

Patient Information

Please Print

(Patient) Last Name _____ First _____ Middle _____

Address _____ City _____ State _____ Zip _____

S.S.# _____ Date of Birth _____ Phone _____

Cell Phone _____ Email Address _____

Sex: M F Marital Status: Married Single Divorced Widowed Legally Separated If a Student: Full Time or Part Time

Employed: Full Time Part Time Retired No

Patient's Employer Name _____ Employer Phone: _____

Emergency Contact (NOT LIVING WITH YOU) _____ Phone _____

Responsible Party Information (If different than above)

(Responsible Party) Last Name _____ First _____ Middle _____

Address _____ City _____ State _____ Zip _____

S.S.# _____ Date of Birth _____ Phone _____

Cell Phone _____ Email Address _____

Insurance Information

We require all insurance information prior to services being provided. Due to the diverse nature of many eye conditions, disorders, and procedures, many of the services we provide are covered by your MAJOR MEDICAL INSURANCE rather than routine vision coverage. Please provide us with the following information even if you believe that you are seeing us for a non-medical reason.

MEDICAL Primary Insurance Co. _____ Policy ID # _____

Policy Holder Name _____ Policy Holder S.S.# _____ Policy Holder Sex: M F

Policy Holder Date of Birth _____ Policy Holder Employer _____

Secondary Insurance Co. _____ Policy ID # _____

Policy Holder Name _____ Policy Holder S.S.# _____ Policy Holder Sex: M F

Policy Holder Date of Birth _____ Policy Holder Employer _____

VISION Primary Insurance Co. _____ Policy ID # _____

Policy Holder Name _____ Policy Holder S.S.# _____ Policy Holder Sex: M F

Policy Holder Date of Birth _____ Policy Holder Employer _____

Secondary Insurance Co. _____ Policy ID # _____

Policy Holder Name _____ Policy Holder S.S.# _____ Policy Holder Sex: M F

Policy Holder Date of Birth _____ Policy Holder Employer _____

Eye Care Center Policies

Please read and sign below

Contact Lenses: If you are a contact lens wearer, there will be an additional charge to your exam for a contact lens evaluation. This fee includes lens selection, evaluation of the lens on the eye, any training required, lens changes if required, and all contact lens related follow up visits. The level of the evaluation fee assessed is based upon the type of contact lenses you wear and the complexity of your prescription.

Financial: Full Payment is due at the time of service. Cash, checks, and credit card are accepted. All refunds or exchanges of material must be done within 30 days of purchase. There are no refunds for any professional services. There is a \$20 fee for returned checks. Any refund due to you of \$5.00 or less will be credited to your account.

Insurance: All co-pays and deductibles are due at the time of service. Please be aware that some, and perhaps all, of the services provided may not be covered. The balance is the responsibility of the patient whether insurance pays or not.

I authorize the release of any medical information to process this and any further claims. I authorize assignment of all medical benefits to the Eye Care Center.

Signature _____ Date _____