Patient Registration

Date:_____

PATIENT INFORMATION

Patient Name:_____ Sex: M F Date of Birth: _____

Address:_____ City:_____ State:_____ Zip:_____

Marital Status: S M D Social Security #:_____ Home Phone:_____

Work Phone:_____ Other:_____ e-mail address:_____

Occupation:_____ Employer Name:_____

EMERGENCY CONTACT

Name:_____ Relationship:_____

Phone #:_____ Other Numbers:_____

NAME OF INSURED OR GUARDIAN

Name (if different from patient):_____ Relationship:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Date of Birth: _____

Social Security #:_____ Employer Name:_____

HOW DID YOU HEAR ABOUT US?

Please Circle: Doctor / Vision Plan / Location / Insurance Provider List / Friend or Relative / Website

Friend or Relative (Whom may we thank?)_____ Whose Website:_____

Advertisement (if so, where?):_____ Other:_____

CONSENT FOR TREATMENT / AUTHORIZATION / RELEASE

I hereby agree and give consent to the treating physician and employees of this office and other associates to diagnose and treat the patient named on this form. I consent to treatment that includes, but may not be limited to, physical examination and other procedures related to the diagnosis and treatment of the patient as determined necessary and appropriate by the treating physician, his/her partners, associates, consultants and staff.

I also request the payment of authorized Insurance benefits due to me be made on my behalf to the physician for any services furnished to me by the physician. I authorize holder of medical information about me to release to a Third Party Payer (Insurance Company) and its agents any information needed to determine benefits or the benefits payable to related services.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of services (not covered by my insurance, or the amount determined to be patient responsibility) rendered on my behalf or my dependents.

Because of the customized nature of eyeglasses, eyeglasses cannot be returned for refund. Lenses will be re-made at no charge if any problems exist. If a refund is demanded, the frame can be returned for complete refund and the lenses can be returned for 50% of the original cost. This does not apply to scratched lenses or damaged frames. A re-make or return must occur within 30 days.

_____ _____

Patient Signature Date Witness Date