PATIENT REGISTRATION

First Name: _____Last: _____MI:____ DOB: ___/____/____

Address: _____ City, State, Zip: _____

Gender: (circle) **M** **F** Preferred language:_____ Ethnicity (Optional) _____

Home phone: ( )_____ Work:_____ Cell: _____

E-mail:_____ Preferred communication:(circle) Phone / text msg / E-mail

How were you referred to our office? Prior patient • Yellow pages • Internet • Friend/Relative • Location

Employer/Occupation: _____ School/Grade: _____

Payment and Insurance information: None VSP MES EyeMed CMSP MediCal Medicare Other:_____

Insurance Subscriber: _____ Insurance ID #_____

Social Security Number: _____

****PLEASE PRESENT YOUR INSURANCE CARDS TO THE FRONT DESK FOR BILLING PURPOSES****

SIGNATURE ON FILE

AUTHORIZATION: (a) I authorize use of my signature on this form for all my insurance submissions. (b) I authorize release of information to all my insurance carriers. (c) I authorize the release of information to opticians/optical suppliers whom I have asked to fill optical prescriptions. (d) I authorize release of information to health care providers for referral purposes, if needed. (e) I authorize payment directly to the Doctor for benefits otherwise payable to me for services rendered. (f) I understand that I am responsible for the balance of fees not paid by Insurance. (g) I understand that payment for services rendered is my obligation regardless of insurance or other third party involvement.

x_____ _____/_____/_____

Patient or Parent/Guardian (if minor) date

I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES.

x_____ _____/_____/_____

Patient or Parent/Guardian (if minor) date

□ PHOTO ID VERIFIED

THANK YOU FOR THE OPPORTUNITY TO SERVE YOU