

Patient Registration Sheet

Name _____ <small style="display: flex; justify-content: space-between; width: 100%;">LastFirstMINickname</small>			
Address _____ _____			
Phone _____ <small style="display: flex; justify-content: space-between; width: 100%;">HomeWorkMobile</small>			
Date of Birth _____		Age _____	Email _____
Occupation _____		S.S# _____	
Employer _____			
Health Insurance Company _____			
Vision Insurance, if applicable _____			
Marital Status: Married Single Divorced Widowed			
How did you hear about us: _____			
If your insurance policy is in someone else's name, please provide the following information about the person who holds the policy:			
Name _____		Date of Birth _____	
Employer _____		S.S# _____	
Address _____		<i>(Address & Phone #s if different from above)</i>	
Phone _____ <small style="display: flex; justify-content: space-between; width: 100%;">HomeWorkMobile</small>			
Authorization for Release of Information and Payment on Account			
<p>I hereby authorize Professionals in Eye Care to file claims related to my care in this office with the appropriate insurance company. I also authorize the insurance company to send payment on my behalf to this office. I understand that I am responsible for any unpaid amounts not paid by my insurance company. I understand that I am responsible for any unsatisfied annual deductibles and that I will receive a bill for those if I do not pay them at the time of my visit.</p>			
<p>My signature on this form shall serve as my signature on file for any and all claims associated with the care which I receive while in this office or under the care of this optometrist.</p>			
Signature _____			
Witness _____		Date _____	