EYECARE REGISTRATION AND HISTORY

PATIENT INFORMATION

Last Name _____

First Name_____ Mr. Ms. Mrs. Dr. Father

Middle Initial_____ Jr. Sr. III IV

Preferred Name_____

Street Address_____

P.O. Box_____

City _____ State_____ Zip Code_____

Birthdate_____/_____/_____ Age_____

Marital Status Single Married Divorced Widowed Other

Employment Other Retired Employed Student FT or PT

Gender M F S.S.N. _____

Alternate Address_____

_____

Patient's Occupation_____

Patient Employed by _____

Contact Information

Home ( ) _____-_____ Cell ( ) _____-_____

Work ( ) _____-_____ Ext _____

Preferred Contact Home Cell Work Best Time_____

Email _____

BILLING INFORMATION

(If SELF: Skip to ***)

Who Is Responsible For This Account? _____

What is the relationship to Patient? _____

Is The Person Responsible A Patient Here? Yes No

Is The Person Responsible The Insurance Holder? Yes No

Last Name _____Date___/___/___

First Name_____ Mr. Ms. Mrs. Dr. Father

Middle Initial_____ Jr. Sr. III IV

Street Line 1_____

Street Line 2_____

City _____ State_____ Zip Code_____

Birthdate_____/_____/_____ Age_____

Gender M F Phone ( ) _____-_____

Name of Employer_____

*** Are There Any Other Patients/Family Members That We Should Include On Your Billing Statement?

Name_____D.O.B_____

Name_____D.O.B_____

Name_____D.O.B_____

Name_____D.O.B_____

IN CASE OF EMERGENCY, CONTACT_____Relationship_____

Home ( )_____-_____ Work( )_____-_____ Ext_____ Cell( )_____-_____

How Did You Find Our Practice? _____ Whom May We Thank for Referring You? _____

Patient's Primary Care Physician _____City_____State_____

What Pharmacy do You Use? _____City_____State_____

Thank you for giving us the opportunity to serve you. We appreciate your business and the confidence you have placed in us.

ASSIGNMENT AND RELEASE:

Payment is due within 30 days of sale. A 1% per month (12% per year) late payment fee will be assessed on any unpaid balance remaining after 30 days.

I also certify that I, and/or my dependent(s), have insurance coverage with _____and assign directly to
(Name of Insurance Company(ies)

VISIONCARE ASSOCIATES INC., all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will remain in effect as long as I have this insurance and no information including names, numbers and/or addresses have been changed or updated.

DATE_____ SIGNATURE _____

PRINT NAME _____
(CIRCLE ONE) Patient Parent Guardian Personal Representative

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone. Signature below is only acknowledgement that you have received or have had the opportunity to receive the Notice of our Privacy Practices:

DATE_____ SIGNATURE _____