Office Registration

Name ______________________________________ SS# __________________________
Address ____
City ______________________________ State __________ Zip Code ___________________
Phone _________________________ Birthdate _____________________ Sex: Male/Female
Cell ___________________________ Email Address __________________________________
Spouse's Name ____
If a minor- Guardian/Parent's Name ____

Insurance Information

Vision Insurance Company Name ____
Policy Number _____________________________________ Group Number ______________
Policy holders Name _____________________________________ Birthdate ______________
Address if different than above ____

Medical Insurance Company Name ____
Policy Number _____________________________________ Group Number ______________
Policy holders Name _____________________________________ Birthdate ______________
Address if different than above ____

Alternate contact person- other than home phone numbers

Name/Relationship __________________________________ Phone _____________________

It is my responsibility to provide all necessary insurance information to process payment of my claim. I authorize payment of my insurance benefits to be made directly to the doctor. As a courtesy, the doctor's office will submit my claims to my insurance carriers, but I understand that I am financially responsible for all services rendered not covered or payable by my insurance carrier including deductibles, co-payments or non-covered services.
If I need an authorization/referral, it is my responsibility to obtain it from my primary care physician prior to my appointment or I will be held responsible for payment of services rendered.
Patients who have no office visit coverage or have no insurance will be expected to pay in full at time medical services are rendered.

Signature ____ Date ______________________