PATIENT REGISTRATION SHEET

Last:______________________________ First: _________________________ M.I.____ Previous Name: ___________________________

Social Security #: ___________________________ Date of Birth:________________________ Age: ______ Sex: M F

Address: ____ City:______________________________ State:_____ Zip: ____________

Home Phone: ( ) ______________________________ Work Phone: ( ) ______________________________

Marital Status: Single Married Divorced Widowed Legally Separated Referred by: _______________________________________

Student Status: Full-time Part-time Not a student Primary Care Provider: ____

Name of Employer: ____ Occupation: _______________________________________

Employer Address: _______________________________________ City:______________________ State: ________ Zip:__________

Name of Spouse: ___________________________ Emergency Contact: _______________________ Phone:( ) _______________

Do you wear contact lenses: Yes____No____ If no, are you interested in contact lenses? Yes___ No ___

INSURANCE INFORMATION

Vision Insurance: _______________________________________ Policy Holder: ______________________________________

Policy Holder DOB: _____________________________________ Relationship to Patient: ______________________________________

Medical Insurance:

PRIMARY: ____ Policy Holder: ____

Policy Holder DOB:____________________________________ Relationship to Patient: _____________________________________

SECONDARY: ____ Policy Holder: ____

Policy Holder DOB:_______________________________________ Relationship to Patient: ______________________________________

REFRACTION FEE: I understand that the refractive service (**a refraction is the test to determine your prescription for glasses)** that I receive is considered a Medicare and private insurance non-covered benefit. I also understand that it is a separate charge not included in the exam that will be billed to my insurance. I will be financially responsible for the refraction fee of **$30.00** and any amount left after my insurance has paid.

Signature: ____ **Date:** ____

Patient Release

I understand that all patient responsible amounts are due at the time services are rendered. I understand that I am financially responsible for all charges. I understand that if services are provided before I am eligible to receive them I will be financially responsible. I request that payment of authorized INSURANCE benefits be made either to me or on my behalf to:
Pablo M. Arregui, M.D., Benjamin N. Gilbert, M.D., Heidi E. Houlihan, M.D., Sean Liston, M.D., or Thomas Seely, O.D. for any services furnished to me by that clinic/supplier. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agency any information to determine the benefits payable for related services.

I understand my signature requests that payment be made and authorized release of medical information necessary to pay the claim. If other insurance is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of information to the insurer or agency shown.

Signature: ____ **Date:** ____