

**PATIENT REGISTRATION SHEET**

Last: \_\_\_\_\_ First: \_\_\_\_\_ M.I.: \_\_\_\_\_ SS#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: M F **E-Mail Address:** \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Emergency Contact Phone: ( ) \_\_\_\_\_

Responsible Party: \_\_\_\_\_ Responsible Party's Phone: ( ) \_\_\_\_\_ DOB: \_\_\_\_\_

Name Of Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**How Did You Hear About Us:** \_\_\_\_\_

**Do You Wear Glasses?: Yes / No Do you Wear Contacts?: Yes / No Are You Interested In Contacts?: Yes / No**

**INSURANCE INFORMATION: Please list the policy holder if other than the patient**

**Vision Insurance:** \_\_\_\_\_ Policy#: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

**Medical Insurance:**

**PRIMARY:** \_\_\_\_\_ Policy#: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

**SECONDARY:** \_\_\_\_\_ Policy#: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

**REFRACTION FEE:** I understand that the refractive service (**a refraction is the test to determine your prescription for glasses/contacts**) that I receive is considered a non-covered benefit by Medicare and most Private insurances. I also understand that it is a separate charge not billable to my medical insurance. I will be financially responsible for the refraction fee of **\$35.00 at the time services are rendered.**

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 M. Liston, M.D., Steven J. Warne, O.D. or Marina Rocchi, 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 authorize 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 signatures authorizes releasing of information to the insurer or agency shown.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_