PATIENT REGISTRATION SHEET

Last: _____ First: _____M.I.: _____SS#:_____

Date of Birth: _____ Birth Sex: M F Gender Identity: _____

E-Mail Address**:** _____ Marital Status: Single Married Divorced Widowed

Mailing Address: _____ City: _____ State: _____ Zip: _____

Physical Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Which number do you prefer to be contacted at (circle one): Home Work Cell

Okay to leave a detailed message? (Circle one) Yes No

Emergency Contact: _____ Emergency Contact Phone: ( ) _____

Responsible Party (If not patient): _____ Relationship to patient: _____

Responsible Party's Phone: ( ) _____

Employer: _____ Occupation: _____

Primary Physician: _____ Pharmacy: _____

How Did You Hear About Us: _____

Race: (Select one or more)
- ❑ American Indian or Alaska Native
- ❑ Black or African American
- ❑ White
- ❑ Unknown / Declined to Report
- ❑ Asian
- ❑ Native Hawaiian/Pacific Islander
- ❑ Other

Ethnicity:
- ❑ Hispanic or Latino
- ❑ Not Hispanic or Latino
- ❑ Decline to specify

Preferred Language: ❑ English ❑ Spanish ❑ Other (please list) _____

INSURANCE INFORMATION
(If card not present please complete this section)

Medical Insurance:

PRIMARY: _____ Policy#:_____

Subscriber Name:_____ Relationship to Patient:_____ Subscriber DOB:_____

SECONDARY: _____ Policy#:_____

Subscriber Name:_____ Relationship to Patient: _____Subscriber DOB:_____

Vision Insurance: _____ Policy#:_____

Subscriber Name:_____ Relationship to Patient: _____Subscriber DOB:_____

REFRACTION FEE

A refraction is a test or procedure performed to determine how well a person sees. This test is performed as part of an eye exam to determine and follow the health of the eyes and sometimes for the purpose of prescribing eyeglasses. I understand that the refractive service I receive is considered a non-covered benefit by Medicare and most Private insurances. I also understand that it is a separate charge not payable by most medical insurance.

____The refraction fee is $40 and due at time of service, whether or not it results in a prescription for eyeglasses.

FINANCIAL AGREEMENT

I agree that in return for services provided to me by Chico Eye Center, I will pay my account at the time services are rendered.

I understand that it is my responsibility to provide accurate insurance information at each visit in order for a claim to be properly filed to the insurance company on my behalf. I understand that it is also my responsibility to pay any deductibles, copays, coinsurance or other balances not paid for by my insurance company. If I do not provide the proper insurance information, I understand that I will be responsible for payment in full. Failure to pay account or to set up agreeable payment arrangements can result in the account being turned over to an outside collection agency.

By signing this form I am requesting payment of authorized insurance benefits to be made on my behalf to Chico Eye Center for services furnished to me by Chico Eye Center. I understand my signature authorizes release of medical information necessary to pay the claim.

It is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

_____ _____

Signature of Patient or Representative Date

_____ _____

Print Name Relationship of Representative to Patient