# Client Registration Form

Date_____

## Registration Information

**Welcome to our office!** Thank you for choosing our office for your eye care services. Please take the time to complete this questionnaire accurately and completely. It helps us do the best job possible for you. This information is held in complete confidence as it is part of your permanent record, and will not be released to anyone unless you authorise its release in writing.

### Patient Information

**Please Print**

(Patient) Last Name_____ First _____Middle _____

Address _____ City_____ State_____ Zip _____

S.S.# _____ Date of Birth_____ Phone_____

Cell Phone_____Email Address _____

Sex: ❑ M ❑ F Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Legally Separated If a Student: ❑ Full Time or ❑ Part Time

Employed: ❑ Full Time ❑ Part Time ❑ Retired ❑ No

Patient's Employer Name _____Employer Phone: _____

**Emergency Contact (NOT LIVING WITH YOU)** _____Phone _____

### Responsible Party Information *(If different than above)*

(Responsible Party) Last Name_____ First _____Middle _____

Address _____ City_____ State_____ Zip _____

S.S.# _____ Date of Birth_____ Phone_____

Cell Phone_____Email Address _____

### Insurance Information

We require all insurance information prior to services being provided. Due to the diverse nature of many eye conditions, disorders, and procedures, many of the services we provide are covered by your MAJOR MEDICAL INSURANCE rather than routine vision coverage. Please provide us with the following information even if you believe that you are seeing us for a non-medical reason.

**MEDICAL**

**Primary** Insurance Co._____Policy ID #_____

Policy Holder Name _____Policy Holder S.S.#_____ Policy Holder Sex: ❑ M ❑ F

Policy Holder Date of Birth _____ Policy Holder Employer _____

**Secondary** Insurance Co. _____Policy ID #_____

Policy Holder Name _____ Policy Holder S.S.#_____ Policy Holder Sex: ❑ M ❑ F

Policy Holder Date of Birth _____ Policy Holder Employer _____

**VISION**

**Primary** Insurance Co._____Policy ID #_____

Policy Holder Name _____Policy Holder S.S.#_____ Policy Holder Sex: ❑ M ❑ F

Policy Holder Date of Birth _____ Policy Holder Employer _____

**Secondary** Insurance Co. _____Policy ID #_____

Policy Holder Name _____ Policy Holder S.S.#_____ Policy Holder Sex: ❑ M ❑ F

Policy Holder Date of Birth _____ Policy Holder Employer _____

### Eye Care Center Policies

***Please read and sign below***

**Contact Lenses:** If you are a contact lens wearer, there will be an additional charge to your exam for a contact lens evaluation. This fee includes lens selection, evaluation of the lens on the eye, any training required, lens changes if required, and all contact lens related follow up visits. The level of the evaluation fee assessed is based upon the type of contact lenses you wear and the complexity of your prescription.

**Financial**: Full Payment is due at the time of service. Cash, checks, and credit card are accepted. All refunds or exchanges of material must be done within 30 days of purchase. There are no refunds for any professional services. There is a $20 fee for returned checks. Any refund due to you of $5.00 or less will be credited to your account.

**Insurance**: All co-pays and deductibles are due at the time of service. Please be aware that some, and perhaps all, of the services provided may not be covered. The balance is the responsibility of the patient whether insurance pays or not.

*I authorize the release of any medical information to process this and any further claims. I authorize assignment of all medical benefits to the Eye Care Center.*

***Signature***_____***Date***_____