

PATIENT REGISTRATION

Male Female Please check this box if you are a winter visitor. If so, please provide both addresses.

MR./MRS./MISS **LEGAL NAME:** _____
(Please Circle One) LAST FIRST MI SPOUSE

LOCAL ADDRESS: _____
STREET APT# CITY STATE ZIP

MAILING ADDRESS: _____
STREET APT# CITY STATE ZIP

HOME PHONE: () WORK: () OTHER: ()

E-MAIL ADDRESS: _____

AGE: DATE OF BIRTH: / / SOCIAL SECURITY #: _____

RESPONSIBLE PARTY: PHONE: () RELATIONSHIP: _____

NAME & ADDRESS OF EMPLOYER: _____

OCCUPATION: _____

EMERGENCY CONTACT: PHONE: ()
(Not in the same household.)

MEDICAL INFORMATION: WHO IS YOUR MEDICAL DOCTOR? _____

ADDRESS: PHONE: ()

INSURANCE INFORMATION

PRIMARY INSURANCE: POLICY HOLDER: _____

GROUP# POLICY # D.O.B. _____

PRIMARY ADDRESS INSURANCE PHONE: ()

SECONDARY INSURANCE: POLICY HOLDER: _____

GROUP# POLICY # D.O.B. _____

SECONDARY ADDRESS INSURANCE PHONE: ()

AUTHORIZATION AND RELEASE

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such care to third party payors and/or other health practitioners. I authorize and request my insurance company and/or Medicare to pay directly to the doctor or doctor's group insurance or Medicare benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I also understand that I will be billed a fee for any returned checks.

Signature of patient or parent, if minor Date Signature of witness

PLEASE NOTE: MOST INSURANCES DO NOT COVER REFRACTION SERVICES.

HOW WERE YOU REFERRED TO OUR OFFICE?

DOCTOR (NAME:) FRIEND/RELATIVE (NAME:)
 NEWSPAPER RADIO/TELEVISION SCREENING YELLOW PAGES REPUTATION
 OTHER _____

VISIT OUR WEBSITE AT www.goodeyes.com