WELCOME TO OUR OFFICE

I CARE
VISION CENTERS

Patient Registration Form

Patient First Name: _____ MI: ____ Last Name: _____

Patient/Guardian Name: _____ MI: ____ Last Name: _____

Address: _____ Apt: ____ City: _____ State ____ Zip: ____

Phone Number Home: _____ Phone Number Day: _____

Patient DOB: _____ Patient SS#: _____

Name of Vision Insurance Plan: _____

Insurance Plan Member Name _____ MI: ____ Last Name: _____

Employer of Member _____ Member ID#: _____

Referred By: _____ e-mail address: _____

I acknowledge that all of the above information is correct and current. I hereby authorize the physician to release any information required to process any claims. I also authorize my insurance benefits to be paid directly to the physician and I understand that I am financially responsible for all non-covered services.

_____ _____
Signature of Patient or Guardian Date

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that all of the above information is correct and current. I hereby authorize the physician to release any information required to process any claims. I also authorize my insurance benefits to be paid directly to the physician and I understand that I am financially responsible for all non-covered services.

By signing this form I confirm that I have been offered a copy of the office Notice of Privacy Practices.

_____ _____
Signature of Patient or Guardian Date

Submit by Email Print Form