REGISTRATION HISTORY

Patient's Name____Date of Birth_______________________

Street Address____ SSN (last four) XXX-XX- _______

City / State / Zip____

Cell Phone (_____)____________________ Home Phone (_____)_________________

Occupation_______________________________________Employer ____________________________________

Email____

May we have your permission to communicate via email regarding prescriptions/appointments? Y/N

Do you wear contact lenses? Y/N Are you interested in getting contacts? Y/N Do you have Diabetes? Y/N

How did you hear about us? Referral by ______________________________ Other___________________________

Or (please choose): Insurance Provider Google/Internet Search Yelp Facebook

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Please initial on the lines indicating that you have seen, read and understand this information given to you today:

ADVANCE BENEFICIARY NOTICE & SIGNATURE ON FILE

I authorize the use of this form on all my insurance submissions. I authorize release of information to all my insurance companies or their representatives. I permit a copy of this authorization to be used in place of the original. I authorize payment direct to my doctor.

I understand that any balance or service not covered by insurance will be my responsibility. Payment for non-covered services is due at time of service. Overdue balances past 6 months (180 days) will be forwarded to collection with a processing fee (20% of balance amount). I will be responsible for all returned check fees ($25).

ADVANCE BENEFICIARY NOTICE & SIGNATURE ON FILE: ________ I have seen, read and understand the policy above.

DILATED FUNDUS EXAM & OPTOS + OCT RETINAL IMAGING POLICY ***(located on the clipboard)***

_____ I have seen, read and understand the policies

YOU MUST **CHOOSE:** _____ Do ***NOT dilate***, I ***PREFER*** retinal imaging for an **additional $49 charge.**

_____ I would like to be **dilated** today **(if you have diabetes, you *MUST* be dilated)**

PRIVACY POLICY: _____ I have seen, read and understand the policy **(located on the clipboard)**.

*****Please be aware that if you have a MEDICAL DIAGNOSIS (i.e., diabetes, hypertension, macular degeneration, glaucoma, etc) we are LEGALLY bound to send your exam to the MEDICAL insurance on file instead of your Vision Plan*****

PATIENT OR GUARDIAN SIGNATURE (self or parent): ______________________________ DATE ______________

INSURANCE POLICY HOLDER (self, spouse, or parent):

NAME ______________________________ DATE OF BIRTH __________________LAST 4 SSN: _________