

# Patient Registration Form

## Patient Information (Please Print)

Date \_\_\_\_\_

Mr.  Mrs.  Ms.  Miss  Dr.  Rev.

Social Security No. \_\_\_\_\_

Full Name \_\_\_\_\_ Nickname \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (H) \_\_\_\_\_ Phone (W) \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Phone (Cell) \_\_\_\_\_ E-mail \_\_\_\_\_

Do you prefer to receive calls at:  Home  Work  Cell  Either

Are you:  Minor  Married  Single  Other \_\_\_\_\_

Employer or school \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_

## Responsible Party

Full Name of person responsible for this account \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Phone (H) \_\_\_\_\_ Phone (Cell) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of employer \_\_\_\_\_ Phone (W) \_\_\_\_\_

Responsible Party E-mail: \_\_\_\_\_

## Insurance Information (Please present your insurance card to be photocopied)

Primary Insurance:  Medical Card  Vision Insurance  VSP  Workers Comp  
 Medicare  Health Insurance  Eye Med  Other \_\_\_\_\_

Name of Primary Insured \_\_\_\_\_ Relationship to patient  Self  Spouse

Insured Date of Birth \_\_\_\_\_ Insured SSN \_\_\_\_\_  Parent  Student

Other \_\_\_\_\_

**DO YOU HAVE ADDITIONAL INSURANCE?**  No  Yes IF YES, PLEASE COMPLETE THE FOLLOWING:

Insurance:  Medical Card  Vision Insurance  VSP  Workers Comp  
 Medicare  Health Insurance  Eye Med  Other \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relationship to patient  Self  Spouse

Insured Date of Birth \_\_\_\_\_ Insured SSN \_\_\_\_\_  Parent  Student

Other \_\_\_\_\_

Reason for today's visit \_\_\_\_\_

When was your last eye exam? \_\_\_\_\_ Doctor \_\_\_\_\_

Check all that you currently wear:  Prescription glasses  Dress  Work Safety  Sport Safety  Sunglasses  
 Readers  Non-prescription glasses

Do you wear contact lenses?  Yes  No If so, what type/brand? \_\_\_\_\_

Are you interested in wearing contact lenses?  Yes  No

PLEASE TURN OVER ~ SIGNATURES NEEDED ON BACK ...

Name \_\_\_\_\_ Date \_\_\_\_\_

## INSURANCE AUTHORIZATION

### Authorization to File for Private Insurance, Medicare and/or Medicaid Benefits

I certify that the information given to me in applying for insurance, Medicaid and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance, Medicaid and/or Medicare benefits, and I authorize payment of these benefits directly to Roger D. Fannin, O.D., PSC, dba Family Vision Health Center on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits payable to related services. If I have other health insurance coverage, my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

\_\_\_\_\_  
*Lifetime Patient/Responsible Party Signature*

\_\_\_\_\_  
*Date*

### Payment Agreement

Payment is due for professional services at the time they are rendered. Materials (glasses, contact lenses, etc.) may be ordered with a 50% downpayment. The balance in full is due when the materials are dispensed. We do not extend credit; however, a layaway plan is available. If you have vision insurance, you must provide information with which we can verify your coverage prior to the completion of your visit.

Unpaid accounts are subject to a service charge of 1.5% per month (18% APR). If your account is referred to a collection agency, court or attorney, you agree to be responsible for all additional charges incurred in the collection of your debt.

I have read and agree to the above payment policy. \_\_\_\_\_  
*Patient or Responsible Party*

If you are signing as responsible party, complete the following:

*Responsible Party Name:* \_\_\_\_\_

*Address:* \_\_\_\_\_

*Relationship to Patient* \_\_\_\_\_

I acknowledge that I have received FVHC's Notice of Privacy Practices. \_\_\_\_\_  
*Initial*

### How were you referred to our office?

Friend/Relative/Other Professional - Name \_\_\_\_\_  
 Radio Ad       Yellow Pages       Newspaper Ad       Mailing       Other \_\_\_\_\_