Patient Registration

Date:_____

PATIENT INFORMATION

Patient Name:_____ Sex: M F Date of Birth: _____

Address:_____ City:_____ State:_____ Zip:_____

Marital Status: S M D Social Security #:_____ Home Phone:_____

Work Phone:_____ Cell:_____ e-mail address:_____

Occupation:_____ Employer Name:_____

NAME OF INSURED OR GUARDIAN/EMERGENCY CONTACT

Name (if different from patient):_____ Relationship:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Date of Birth: _____

Social Security #:_____ Employer Name:_____

Name of Emergency Contact:_____ Phone#_____

HOW DID YOU HEAR ABOUT US?

Please Circle: Doctor / Vision Plan / Location / Insurance Provider List / Friend or Relative / Website

Friend or Relative (Whom may we thank?)_____ Whose Website:_____

Advertisement (if so, where?):_____ Other:_____

CONSENT FOR TREATMENT / AUTHORIZATION / RELEASE

I hereby agree and give consent to the treating physician and employees of this office and other associates to diagnose and treat the patient named on this form. I authorize the office of Devine Eyes to text, e-mail and or fax on my behalf to correspond with my doctor regarding my eye health care. I consent to treatment that includes, but may not be limited to, physical examination and other procedures related to the diagnosis and treatment of the patient as determined necessary and appropriate by the treating physician, his/her partners, associates, consultants and staff.

I also request the payment of authorized Insurance benefits due to me be made on my behalf to the physician for any services furnished to me by the physician. I authorize holder of medical information about me to release to a Third Party Payer (Insurance Company) and its agents any information needed to determine benefits or the benefits payable to related services.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of services (not covered by my insurance, or the amount determined to be patient responsibility) rendered on my behalf or my dependents.

_____ _____

Patient Signature Date Witness Date