Patient Registration Form

Date: _____

Last Name: _____ First Name: _____ SS#: _____

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

Sex: _____ Age: _____ Date of Birth: _____ Marital Status: _____

Cell Phone Number: _____ Email: _____

Occupation / Grade: _____ Employer / School: _____

Emergency Contact: Last Name: _____ First Name: _____

Relationship: _____ Cell Phone: _____ Email: _____

How did you find out about our office? _____

Insurance Information

Person Responsible for account: Last Name: _____ First Name: _____

Relationship to Patient: _____ Date of Birth: _____ SS#: _____

Please Provide front and back copies of your Vision and Medical Insurance Cards and Driver's License

Medical Insurance Company: _____ Contract #: _____

Subscriber Number: _____ Group #: _____

Vision Insurance Company: _____ Contract #: _____

Subscriber Number: _____ Group #: _____

Secondary Insurance

Insurance Company: _____ Contract #: _____

Subscriber Number: _____ Group #: _____

Assignment and Release

I, the undersigned, hereby authorize and direct my insurance carrier to pay directly to Professional Eye Care, Inc, dba Outreach Vision all primary and secondary insurance benefits due to me under my insurance plan. I authorize any holder of medical information to release to the Health Care Financing Administration and its agents any information needed to determine these benefits. I acknowledge that the HIPPA notice of privacy practices has been made available to me and understand that it is available to view at outreachvision.com.

Patient Signature: _____ Date: _____