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 ❑ Parent ❑ Student ❑ Other _____

Insured Date of Birth _____ Insured SSN _____

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 ❑ Parent ❑ Student ❑ Other _____

Insured Date of Birth _____ Insured SSN _____

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 _____