Patient Registration Form

PATIENT INFORMATION

NAME (Last, First, Mi)____

ADDRESS____

CITY____________________ STATE____________ ZIPCODE________

PHONE ☐ Home (   )__________ ☐ Cell (   )__________ ☐ Wk (   )__________
Please check box next to best number to call

DATE OF BIRTH ________________ SEX M F SOCSEC ________________

EMAIL ____________________ OCCUPATION ________________

INSURANCE INFORMATION

– Medical Insurance –

Primary____________________ Secondary____________________

Member's Name________________ Member's Name________________

Member’s DOB:________________ Member’s DOB ________________

ID#____________________ ID#____________________

– Vision Insurance –

Primary____________________ Secondary____________________

Member's Name________________ Member's Name________________

Member’s DOB:________________ Member’s DOB ________________

ID#____________________ ID#____________________

EMERGENCY INFORMATION

In case of emergency please notify______________________________

PHONE# (   ) ________________ Relationship to patient ________________

REFERRED BY: ____

FINANCIAL RESPONSIBILITY

I permit a copy of this authorization to be used in place of the original, and request payment of insurance benefits to ROCKAWAY BEACH OPTOMETRY. I understand and accept financial responsibility for all and any service rendered to me. I understand my insurance company is billed as a courtesy to me and payment of any bill is my responsibility.

PATIENT OR GUARDIAN SIGNATURE ____________________ DATE __________

NOTICE OF PRIVACY PRACTICES

A "Notice of Privacy Practices" that describes how my protected health information is used and disclosed has been made available to me. I understand I may request a printed copy at anytime.

PATIENT INITIALS ______ DATE________

WARRANTY INFORMATION RECEIVED

PATIENT INITIALS ______ DATE________