REGISTRATION SLIP

FORM: 012

OFFICE USE ONLY: PATIENT # ____________ PHYSICIAN # __________ DATE ____________
FINANCIAL CLASS ______________________________
REFERRING PHYSICIAN (IF ANY) ______________________________

Patient Name (Last, First, M) Please Print			Date of Birth / /	Age	Social Security No.
Address (Street) (City - State - Zip)			Home Phone ( )		Work Phone ( )
Sex M F	Marital Status M S D W	Occupation	Patient's or Parent's Employer		
Spouse or Parent's Name			Spouse or Parent's Work Phone ( )		
Spouse or Parent's Employer	Spouse's Occupation		Spouse's Social Security No.		
FAX No. or E-Mail Address:			Cell Phone No. ( )		
Is today's visit due to getting hurt on the job? Yes No	Date of Injury		Contact person		
If yes, please explain: ______________________________					
Emergency Contact			Phone ( )		Relationship to Patient
Nearest Relative not living with you			Phone ( )		Relationship to Patient
Person responsible for bill if other than patient: Name:			Phone ( )		Relationship to Patient
Address:					

ACKNOWLEDGMENT: I have reviewed the above and verified that it is correct. I understand all charges are due and payable in full at the time of service and I agree to abide by this policy. If I have HMO insurance and do not submit a referral number to this office, I realize that I am responsible for the charges incurred without a referral number. **I am also responsible for any co-pays and deductibles due according to my insurance.** For services such as surgery, etc., if I have Medicare/Medicaid, I authorize any and all insurance companies to pay benefits directly to the doctor unless I have paid them myself in which case the benefits would come to me. I also authorize the release of medical information necessary to handle my claims. I hereby authorize the release of any and all information pertaining to any office or hospital services rendered to me by said physician as well as information including the diagnosis and treatment rendered to me by previous physicians, hospitals, or other medical facilities and/or personnel.

Federal law suggests your physician disclose to you any ownership interest your physician may have in any entity to which you are referred for further services.

ROUTINE EYE EXAMS/REFRACTIONS: Government agencies DO NOT cover routine eye exams. If I have MEDICARE, I will be responsible for the visit plus a $20.00 refraction fee. If I have private insurance and it DOES NOT cover routine eye exams or refractions, I will be responsible for these charges.

I HAVE READ THE ABOVE ACKNOWLEDGMENT AND FULLY UNDERSTAND THE TERMS AND CONDITIONS:

______________________________________ SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

______________________ DATE