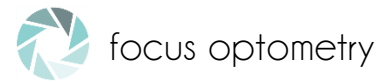


Welcome to our office!
Patient Registration Form



Today's date:			OFFICE USE: Patient's Chart #:		
PATIENT INFORMATION					
Last name:	First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number:		
Street address:				Home phone :	
City:			State:	ZIP Code:	
Email Address:				Cell phone:	
I do consent to the use of email/electronic communication with Focus Optometry. <input type="checkbox"/> Yes <input type="checkbox"/> No					
Occupation: <input type="checkbox"/> Student		Employer/School:		If student, grade:	
How did you hear about us?					
Family members seen here:					

INSURANCE INFORMATION			
Person responsible for bill: <input type="checkbox"/> Self	Address:	<input type="checkbox"/> Same as above	Home phone : <input type="checkbox"/> Same as above
Primary insurance: <input type="checkbox"/> Self Pay <input type="checkbox"/> VSP <input type="checkbox"/> MES <input type="checkbox"/> EyeMed <input type="checkbox"/> Other			
Subscriber's name:	Birth date:	S.S.N.:	Policy no:
Relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			
Subscriber's employer:			
Secondary insurance (if any) : <input type="checkbox"/> VSP <input type="checkbox"/> MES <input type="checkbox"/> EyeMed <input type="checkbox"/> Other			
Subscriber's name:	Birth date:	S.S.N.:	Policy no:
Relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			

AUTHORIZATION, RELEASE, AND ACKNOWLEDGEMENT	
<p>The above information is true to the best of my knowledge.</p> <p>I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I acknowledge full financial responsibility for the services provided by Focus Optometry and also hereby authorize my insurance benefits be paid directly to Focus Optometry.</p> <p>I also acknowledge that Focus Optometry's Notice of Privacy Practices is available for me to read in the reception area at any time and copies will be given upon request.</p> <p>I understand there are no refunds given on glasses already made by the laboratory; remake or exchanges only. I understand that I may only exchange unopened and unmarked contact lens boxes. All orders not dispensed within 30days of notification will forfeit deposit unless prior arrangements are made.</p>	
<p>_____</p> <p><i>Patient/Guardian signature</i></p>	<p>_____</p> <p><i>Date</i></p>