Welcome to our office!
Patient Registration Form

focus optometry

Today's date:			**OFFICE USE:** Patient's Chart #:		
PATIENT INFORMATION					
Last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Birth date:	Age:	Sex: ❑M ❑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. ❑Yes ❑No					
Occupation: ❑ Student		Employer/School:			If student, grade:
How did you hear about us?					
Family members seen here:					

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

AUTHORIZATION, RELEASE, AND ACKNOWLEDGEMENT

The above information is true to the best of my knowledge.
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.

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.

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.

Patient/Guardian signature *Date*