

PATIENT REGISTRATION

Date: _____ Date of Birth: _____ Marital: _____ Sex: M F

Race/Ethnicity: Caucasian Hispanic African American Asian Native American Other: _____

Name: _____
(First) (Middle) (Last)

Local Address: _____
(Street / P.O. Box No.) (City) (State) (Zip)

Permanent Address if different than above: _____
(Street / P.O. Box No.) (City) (State) (Zip)

Local Phone: _____ Work Phone: _____ Northern Phone: _____

Cellular Phone: _____ E:Mail Address: _____

S.S. #: _____ Occupation: _____ Place of Employment: _____

In Case of Emergency Notify: _____ Relationship: _____
(Name) (Phone)

(Primary Medical Insurance) (Vision Insurance) (Policy Holder ID #)

OFFICE POLICY REGARDING PAYMENT

We will file your insurance on your behalf for today's visit. We accept Medicare assignment. Today you are responsible for paying deductibles, copays, as well as fees for non-covered services.

Primary Medical Insurance Holder: _____

DOB: _____ S.S. #: _____ Relationship to Patient: _____

Were you sent to our office by another physician? Yes No If yes, who: _____

If other than a physician referral please check the one that best applies to how you heard about us.

Relative/Friend: Name: _____

Magazine Facebook/Email Insurance Website

Other (please be specific): _____

LIFETIME SIGNATURE AUTHORIZATION

In cases where private insurance and or Medicare claims are to be filed, the following form should be completed. In order for us to submit a claim on your behalf for services, we must have your authorization to release medical information.

I hereby authorize Bonita Vision Center to release all medical information and to submit insurance and other claims, including appeals, on my behalf and request payment of Medicare benefits either to myself or to the party who accepts assignment. I understand that I, the patient, am financially responsible for bills submitted and for any balance not paid by insurance. A copy of this signature is valid as the original.

I also give my permission for a report of my evaluation, treatment, and follow up evaluation to be sent to my referring physician and/or family physician.

I have read the above Office Policy and Lifetime Signature Authorization completely. I understand and accept the policy.

Signed: _____ Witness: _____ Date: _____

FOR MINORS:

I give my permission for my minor child, _____, to be treated by Bonita Vision Center.

Signature of Parent or Guardian: _____