VISION CARE SPECIALISTS, P.C.

PATIENT REGISTRATION FORM

(Please type in fields and save form or print out and fill in)

OFFICE USE ONLY
PT#:

PATIENT INFORMATION

NAME: Last:	**First:**	**MI:**	**Date of Birth:**
Street Address:			**Nickname (if applicable):**
City:	**State:**	**Zip Code:**	**Sex:** ☐ M ☐ F **Marital Status:** ☐ M ☐ D ☐ S ☐ W
Home Phone: ( ) -		**Cell Phone:** ( ) -	
Email:		**Phone Preference (choose one):** ☐ Home ☐ Cell	

Language: ☐ English ☐ Spanish ☐ Portuguese ☐ Chinese ☐ Russian ☐ French ☐ Italian ☐ Other: ☐ Decline	**Race:** ☐ White ☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander ☐ Decline	**Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

Employer:	**Type of work you do:**
Primary Care Physician:	**Address and Phone:**
How did you hear about our office?	
IF PATIENT IS UNDER 18 YEARS OF AGE, GUARANTOR (person responsible for payment) is:	
Name: **Address:**	**Phone:** ( ) - **Date of Birth:**

Choose one preference for appointment/recall reminders: ☐ **Text** ☐ **Email** ☐ **Home Phone** (automated) ***(Land Line Only)***

CONTACT LENS SERVICE FEES

Most insurance carriers do not cover procedures related to contact lenses unless they are deemed "medically necessary". Most contact lenses are considered cosmetic. Contact lens wear increases the complexity of your eye examination and increases the possibility of developing problems. Additional fees for contact lens evaluations apply. **Please ask us for a quote of these additional fees.**

AUTHORIZATIONS (ASSIGNMENT AND RELEASE)

I authorize payment of benefits directly to Vision Care Specialists, P.C. for services rendered. I authorize release of any medical information that may be required in determination of such benefits. I also authorize the release of medical information to my other health professionals as needed.

I understand that some services may require approval of my primary care physician (PCP) for coverage and that, if I do not obtain that approval (referral), I am financially liable for the services.

I understand that my insurance carrier may not cover some services and products and that benefit information provided by the insurance carrier does not constitute approval or guarantee payment. **Deductibles and fees not paid by my insurance carrier will be my responsibility.**

Signature_____ Date_____

Patient (Parent/Guardian if under 18)

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been given a copy of the Notice of Privacy Practices.

Signature_____ Date_____

Patient (Parent/Guardian if under 18)