PATIENT REGISTRATION

Thank you for choosing our office for your eye care. In order to provide you the best care possible, we ask that you answer the questions on this and the following pages.

1. PATIENT INFORMATION

DATE:

PATIENT'S NAME: LAST FIRST M.I.

HOME STREET ADDRESS CITY STATE ZIP

DAYTIME PHONE ( ) HOME ( )

WORK ( ) ext CELL ( )

☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ MINOR SOCIAL SECURITY (last 4 only) ___ ___ ___ ___

E-MAIL DATE OF BIRTH AGE ☐ MALE ☐ FEMALE

2. INSURANCE

VISION INSURANCE	MEDICAL / OTHER INSURANCE (PPO Only)
INSURANCE COMPANY	INSURANCE COMPANY
EMPLOYER NAME	EMPLOYER NAME
SUBSCRIBER'S NAME	SUBSCRIBER'S NAME
SUBSCRIBER'S SSN	SUBSCRIBER'S SSN
ID #	ID #
DATE OF BIRTH RELATIONSHIP TO PATIENT	DATE OF BIRTH RELATIONSHIP TO PATIENT

INSURANCE ASSIGNMENT AND RELEASE: I certify that I, and/or my dependent(s), have insurance coverage as described above and assign directly to Fouad Melamed, O.D. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient/Guardian Signature: _____ **Date:** _____

3. PRIVACY PRACTICES

I acknowledge that I have read and fully understand the Notice of Privacy Practices.

Patient/Guardian Signature: _____ **Date:** _____

4. PLEASE LET US KNOW

IS ANY FAMILY MEMBER A PATIENT OF OURS? NAME RELATIONSHIP

HOW DID YOU FIND US? ☐ INTERNET ☐ YELLOW PAGES ☐ VSP/INSURANCE ☐ DOCTOR ☐ REFERRAL

WHOM MAY WE THANK FOR REFERRING YOU? _____