REGISTRATION

(PLEASE PRINT)

Appointment Date: ______________

Patient: ____
Last Name First Name M.I.

Date of Birth: ______________________________

Street Address: ____

City: ___________________________________ State:________________ Zip: __________________

Home Phone: ______________________________ Cell Phone:____________________________

Email Address: ___________________________________ Social Security:_______________________

Sex: ___M __F ____Single ____Married ____Widowed ____Separated
____Divorced

Responsible Party (if a minor): ____________________________ Relationship: _____________________

Patient Employed By: _______________________________________

Occupation: ______________________________ Business Phone:_________________________

Do you have **Vision Insurance** (covered for a routine eye exam)? ___No ___Yes

Name of Insurance Company: ____

Name of Policy Holder:____

Policy Holder Date of Birth:____

Policy Holder Social Security #:____

Primary Care Physician: ________________________________ Phone:__________________________

In case of emergency, notify:_____________________________ Phone:__________________________

ASSIGNMENT AND RELEASE:

I, the undersigned, have insurance coverage and assign directly to **High Mountain Eyecare** all medical 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 my insurance submissions.

Signature of Insured/Patient:______________________________________ Date:______________________