PATIENT REGISTRATION FORM

PATIENT NAME:____
(Last) (First) (Middle)

ADDRESS:____
(Street) (Apt.#) (City) (State) (Zip)

HOME PHONE:________________________SEX:__________MARITAL STATUS:M__S__D__W__

CELL #:___________________ S.S. #:_____________________ DATE OF BIRTH______________

EMPLOYER:________________________ADDRESS:____________________________________
(Street) (City) (Zip)

PATIENT'S WORK PHONE___________________SPOUSE'S NAME:________________________

SPOUSE'S EMPLOYER:__________________________SPOUSE'S WORK PHONE:_____________

SPOUSE'S DATE OF BIRTH_______________SPOUSE'S SOCIAL SECURITY #:______________

EMERGENCY CONTACT #__________________________NAME____________________________

IF THE PATIENT IS A MINOR OR STUDENT

FATHER'S NAME:_________________________________HOME PHONE:____________________

STREET ADDRESS:____

SOCIAL SECURITY NUMBER:_______________ FATHER'S DATE OF BIRTH:________________

FATHER'S EMPLOYER AND ADDRESS:____

WORK PHONE:________________________

MOTHERS NAME:_________________________________HOME PHONE:____________________

STREET ADDRESS:____

SOCIAL SECURITY NUMBER:______________MOTHER'S DATE OF BIRTH: ________________

MOTHER'S EMPLOYER AND ADDRESS:____

WORK PHONE:_________________________

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:____
(Name) (Address)

POLICYHOLDER'S NAME:________________________________ID NUMBER:_______________

GROUP NUMBER:_____________________PAT. RELATIONSHIP TO INSURED:______________

SECONDARY INSURANCE COMPANY:____
(Name) (Address)

POLICYHOLDER'S NAME:_________________________________ID NUMBER:______________

GROUP NUMBER:_____________________PAT. RELATIONSHIP TO INSURED:______________

IF I HAVE INSURANCE: I hereby authorize Pleasant Valley Ophthalmology to furnish information to my insurance carriers concerning treatment provided by Drs. Blair and Schmucker and I hereby irrevocably assign to Pleasant Valley Ophthalmology all payments for medical services rendered.

FOR ALL PATIENTS: I understand that I am financially responsible for all charges whether or not covered by insurance.

DATE:____________________SIGNATURE:____

YOU MUST MAKE US AWARE OF ANY VISION INSURANCE BEFORE SERVICES ARE RENDERED. RETROACTIVE AUTHORIZATIONS WILL NOT BE ACCEPTED. THIS INCLUDES BUT IS NOT LIMITED TO VISION SERVICE PLAN AND SUPERIOR VISION. YOU ARE ALSO RESPONSIBLE FOR OBTAINING ANY NECESSARY REFERRALS.