

Family Eyecare Center Doctor of Optometry Patient Registration Record

Patient's Name: _____ Date of Birth: ____/____/____
Address: _____ State of Birth _____ Age: _____
City/State/Zip Code: _____ Mother's Maiden Name _____
Home Phone: () _____ Business/Daytime Phone: () _____
Social Security Number: _____ Email Address: _____
Occupation: _____ Hobbies: _____
Person responsible for payment if different than patient: _____

Name	Address	Daytime and Home Phone
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Vision Insurance:

Medicare No Yes ID Number: _____

VSP No Yes ID Number: _____

Other: ID Number: _____

Do not have vision insurance

Method of Payment: Cash Check Credit Card

Do you or anyone in your family have a history of any of the following? Please state the relationship to the patient.
(e.g.: self, mother, father, grandmother, grandfather, etc.)

<input type="checkbox"/> Hypertension _____	<input type="checkbox"/> Blindness _____
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Eye Operations _____
<input type="checkbox"/> Allergies _____	<input type="checkbox"/> Cataract _____
<input type="checkbox"/> Thyroid Disease _____	<input type="checkbox"/> Eye Injury _____
<input type="checkbox"/> Arthritis _____	<input type="checkbox"/> Glaucoma _____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Recurrent Eye Infections _____

Please list any medications you are presently taking: _____

Are you allergic to any medications? _____

Do you use cigarettes/tobacco? _____ Alcohol? _____ Other substance(s)? _____

What is the nature of this visit? _____

Your primary care physician is _____

Your previous eye practitioner was _____ OD MD

When was your last eye exam? _____ years ago.

In case of an emergency, please contact: _____

Name	Relation	Address	Daytime Phone
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Referral: Insurance list Search Engine Signage Friend/Relative _____

Assignment of Benefits/Financial Agreement

I hereby give authorization for payment of insurance benefits to be made to John J. Riggs, O.D. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, 1.5 % per month finance charge, and reasonable attorney's fees. If an account is sent to a collection agency, the fee will be 30% of the charge owed and will be added to the total amount due. All fees are due and payable at the time of service unless otherwise agreed upon. No records or prescriptions will be released until payment in full is received. I hereby authorize this healthcare provider to release all information necessary to secure all payment of benefits. I understand that replacement of a frame(s) under warranty is subject to a shipping/handling fee. I understand and agree that if I or any member of my family miss a scheduled appointment and am not able to cancel with at least 24 hours notice that I will be billed. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature: _____ Date: _____