Patient Registration Form

Today's Date: _________________ Referred By: ________________________________

Patient Name: ________________________Birthdate:____________ Soc. Sec. #: ________________ Sex: F M

Address Street: ____ City: ________________________________

State: _______ Zip: _____________ Email: ____

Phones: Home (____)________________ Work (____)________________ Cell (____)___________________

Married ___ Single ___ Divorced ___ Widowed ___ Spouse's Name ___________________________________

Reason for Referral: ____

Emergency Contact

Name: _____________________ Phone: ______________Work: ______________Cell:___________________
Address: ____ Relationship to Patient: ____________________

Insured's Name ____________________ Soc. Sec. #___________ Relationship to Patient_________________
Insured's Address ________________________________ Home Phone ___________Work #______________
Insured's Employer____ Employer's Phone _________________
Employer's Address ____

Primary Insurance Name______________________________ Relationship to Patient ____________________
Primary Insurance Company Address____________________________ Insurance Phone #________________
Contract #________________ Group #_____________ Service Code ___________ Effective Date __________

Secondary Insurance Subscriber Name____________________________________ Birthdate______________
Secondary Ins. Subscriber Address________________________ Relationship to Patient __________________
Secondary Insurance Name ___________________________________ Ins. Phone ______________________
Secondary Ins. Comp. Address ____
Contract #______________Group #________________ Service Code__________ Effective Date___________

I authorize any holder of medical or other information about me to release to my insurance carriers or intermediaries; any medical information needed for this or any other related medical claim. I request payment of authorized insurance benefits to be made to Gran View Ophthalmology, PLC. However, I realize that I as the patient am responsible for balances that are not covered or are unpaid by my insurances.

The Refraction (measurement for glasses) Fee ($25.00) is a non-covered service for Medicare and most health insurances, however it is a part of a complete exam and will be done unless you request otherwise.

____ ____________________

Signature (Patient, or if minor parent) Date

Revised 06/2012