Verdier Eye Center

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VerdierEyeCenter.com

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PATIENT REGISTRATION FORM

PATIENT INFORMATION

☐ Mr. / ☐ Ms. / ☐ Mrs. / ☐ Miss / ☐ Dr. _____ _____ _____
First Name Middle Initial Last Name

Social Security #: _____ Birth Date: _____ Age:_____

Race: _____ Ethnicity: ☐ Decline to Specify / ☐ Hispanic/Latino / ☐ Not Hispanic/Latino Sex:_____

Preferred Language:_____ Email Address: _____

Address: _____ City: _____ State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

☐ Married (Spouse's Name: _____) / ☐ Divorced / ☐ Single / ☐ Widowed / ☐ Other

Employer:_____ Occupation: _____

Address: _____ City: _____ State: _____ Zip:_____

Preferred Pharmacy: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip:_____

Optometrist/Ophthalmologist: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip:_____

Family Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip:_____

IN CASE OF EMERGENCY CONTACT

Name: _____ Contact Phone: _____ Relationship: _____

INSURANCE INFORMATION

Primary Insurance

Insurance Name: _____

Insurance ID #: _____

Group #: _____ Effective Date: _____

Name of Policy Holder:_____

Policy Holder Date of Birth: _____

Relationship to Patient: _____

Secondary Insurance

Insurance Name: _____

Insurance ID #: _____

Group #: _____ Effective Date: _____

Name of Policy Holder:_____

Policy Holder Date of Birth: _____

Relationship to Patient: _____

PERSON RESPONSIBLE FOR ACCOUNT (IF DIFFERENT FROM PATIENT)

Full Name:_____ _____ _____ Birth Date: _____ Sex: _____
First Name Middle Initial Last Name

Social Security #: _____ Relationship to Patient: _____

Address: _____ City: _____ State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

The Patient or Guarantor is responsible for payment in full of all services rendered by the physicians or employees of Verdier Eye Center, PLC. Payment in full is expected at the time of service unless arrangements are made in advance or we have a contract to participate with your insurance carrier.

AUTHORIZATION, ASSIGNMENT, AND RESPONSIBILITY OF ACCOUNT

I hereby authorize Verdier Eye Center, PLC to release to the above insurance companies and/or their intermediaries and/or carriers any medical information needed for claims reimbursement. I hereby acknowledge and accept responsibility for payment in full of all services rendered to me by Verdier Eye Center, PLC.

Patient/ Guardian Signature: _____ Date: _____