**Verdier Eye Center, PLC**

**Patient Registration Form**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Mr Ms Miss Patient’s Last Name First Name Middle Initial  Mrs Dr | | | | | Sex | Birth date | | Age |
| Social Security # | Race | | **Ethnicity Please Circle An Option**    1. Declined to Specify 2. Hispanic/ Latino  3. Not Hispanic/ Latino | | Preferred Language | | | |
| Address | | | | City | State | | Zip Code | |
| E-mail address | | Home Phone # | | Work Phone # | Cell Phone # | | | |
| Employer Name | | Occupation | | Employer Address | | | | |
| Name of Spouse | | Spouses Birth date | | Appointment Requested By | | | | |
| Optometrist/Ophthalmologist | | Address/Phone | | | | | | |
| Family Physician | | Address/Phone | | | | | | |

**In Case of Emergency Contact**

|  |  |  |
| --- | --- | --- |
| Name | Phone # | Relationship to Patient |

**Insurance Information**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Primary Insurance** | | | **Secondary Insurance** | | |
| Insurance Name | | | Insurance Name | | |
| Insurance ID # | | | Insurance ID# | | |
| Group # | Effective Date | | Group # | Effective Date | |
| Name/Date of Birth of Policy Holder | | Relationship to Patient | Name/Date of Birth of Policy Holder | | Relationship to Patient |

**Person Responsible for Account (if different from patient)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Last Name First Name Middle Initial | | | | Date of Birth | | Sex |
| Social Security # | Relationship to Patient | Home Phone # | Work/Cell Phone # | | | |
| Address | | City | | State | Zip Code | | |

*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 RESPONSIBILTY 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**