Verdier Eye Center, PLC
Patient Registration Form

Mr Ms Miss Mrs Dr	Patient's Last Name	First Name	Middle Initial	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 herby acknowledge and accept responsibility for payment in full of all services rendered to me by Verdier Eye Center, PLC.

Patient Signature: _____ **Date:** _____