River Vale Eyecare

REGISTRATION

(PLEASE PRINT)

Appointment Date: _____

Patient: _____
Last Name First Name M.I.

Date of Birth: _____

Street Address: _____

City: _____ State:_____ Zip: _____
Home Phone: _____ Cell Phone:_____
Email Address: _____ Social Security:_____

Sex: ___M __F ____Single ____Married ____Widowed ____Separated ____Divorced

Responsible Party (if a minor): _____ Relationship: _____

Patient Employed By: _____
Occupation: _____ Business Phone:_____

Do you have **Vision Insurance** (covered for a routine eye exam)? ___No ___Yes
Name of Insurance Company: _____
Name of Policy Holder:_____
Policy Holder Date of Birth:_____
Policy Holder Social Security #:_____

Primary Care Physician: _____ Phone:_____
In case of emergency, notify:_____ Phone:_____

ASSIGNMENT AND RELEASE:
I, the undersigned, have insurance coverage and assign directly to **River Vale Eyecare** all medical benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Patient:_____ Date:_____