PATIENT REGISTRATION FORM

Name____ **Date of Birth**________________

Address___________________________City, State________________ Zip Code_________

Home Phone: ____

Cell Phone:____

Work Phone:____

Email:____

Do you prefer □Email or □Text Message appointment reminders?

Sex: □Male □Female □Other Marital Status: □Single □Married □Widowed □Divorced

Employer___________________ Occupation_________________ □ Full-time □Part-time □Student □ Retired □ Un-employed

Primary Care Physician___________________________ Phone ____________________________

Vision Plan: □ VSP □EyeMed □ Other______________

Subscriber's Name_________________________ ID#___________________________

Relationship to patient____________ Subscriber's Date of Birth ________________

Subscriber's Address (if different than above)____

Medical Insurance: ____________________________

Subscriber's Name_________________________ ID#___________________________

Relationship to patient____________ Subscriber's Date of Birth ________________

Subscriber's Address (if different than above)____

Emergency Contact Person

I grant permission to share my medical information with this contact.

Name_________________________ Number__________________ Relationship____________

Privacy Policy

I hereby acknowledge that I have received a copy of the Lori A. Heyler, OD LLC 's Notice of Information Practices and I understand that the notice describes how this office uses and discloses my medical and billing information.

Signature_____________________________________ Date________________

Assignment of Insurance Benefits

I hereby authorize payment directly to Lori A. Heyler, OD LLC from my vision plan and/or health insurance. I understand that I am responsible for charges not covered by my insurance.

Signature_____________________________________ Date_________________