Mondo Optical

Patient Registration Form
Please Print **Date**_____

Name:_____ Sex: ____F____M SS#_____
Address:_____ City/State/Zip:_____
Phone:_____ Cell Phone:_____ Age:_____ DOB:_____
Marital Status: Single_____Married_____Divorced /Separated_____Widow/Widower_____
Responsible Party (if patient is a minor)_____
Patients Employer:_____ Occupation_____
Employers Address:_____ Work Phone:_____
Emergency Contact:_____ Phone:_____
Spouse/Significant Other:_____DOB:_____ SS#_____
Spouse/Significant Others Employer:_____ Occupation:_____
Employers Address:_____ Work Phone:_____
Email Address_____

Insurance Information

Primary Insurance Company:_____
Subscriber Name:_____ ID#_____
SS#_____ DOB:_____
Secondary Insurance Company:_____
Subscriber Name:_____ ID#_____
SS#_____ DOB:_____

HIPPA Documentation
Please answer all questions and then sign and date

1. I acknowledge that I have been given the opportunity to read and/or receive a copy of *Mondo* Optical's Privacy Notice. Y N
2. Leave Appointment message on:

			Leave other medical info on:		
Answering Machine	Y	N	Answering Machine	Y	N
Office Voice Mail	Y	N	Office Voice Mail	Y	N
W/Person listed below	Y	N	W/Person listed below	Y	N
Cell Phone	Y	N	Cell Phone	Y	N

3. Person(s) authorized to discuss the above person and relationship

_____ _____

*** I consent to have the practice use and disclose my protected health information for payment, treatment and health care operations purposes, and for such other purposes that are permitted under HIPPA or other federal or state law without my permission***
*** I authorize the payment of medical benefits to the above stated physician or supplier for services rendered***
***I understand that I am responsible for any charges my insurance company denies or does not cover for any services rendered or materials purchased. I also understand that a quote of benefits by my insurance company is not a guarantee of payment for that amount. ***
Signature_____ Date_____