VALLEY VISION CARE
MICHAEL J. YUHAS, OD

132 Market Street
Johnstown, PA 15901

PATIENT REGISTRATION FORM

Last Name: _____ First Name: _____ Middle Initial: ___

Male___ Female___ Date of Birth: _____

Marital Status: Single Married Divorced Widow (circle one)

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Mobile Phone: _____

Social Security # _____

Primary Care Physician: _____

Referring Physician: _____

Place of Employment: _____

Nearest Relative or Person whom we may contact in case of an Emergency

Name: _____ Relationship: _____

Address: _____ Telephone: _____

Assignment of Benefits Authorization for Treatment:

I hereby authorize treatment and authorize direct payment of surgical/medical benefits to Valley Vision Care for services rendered by Michael J. Yuhas, OD in person or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance. I request that payment of authorized benefits be made on my behalf.

PRINT PATIENT NAME: _____

SIGNATURE: _____ DATE:____/____/_____

DATE: ____/____/_____ DATE:____/____/_____