CROSS ROADS EYE CARE LLC
Family Optometry
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WELCOME TO CROSS ROADS EYE CARE!

PATIENT REGISTRATION

PERSONAL INFORMATION					
Patient Name Last First M.I.		Birthdate	Age	Social Security #	
Address	City		State	Zip Code	
Home Phone ( )	Business Phone ( )	Cell Phone ( )	E-mail Address		
Have we seen other members of your family? If yes, whom?		Whom to contact in case of emergency? Name	Phone		

ACCOUNT INFORMATION				
Primary Insured OR Person Responsible for Payment Last First M.I.	Relationship	Birthdate	Social Security #	
Address	City	State	Zip Code	
Home Phone ( )	Business Phone ( )	Cell Phone ( )	Employer	

HEALTH INSURANCE		
Vision Insurance Co	Policy #	Group #
Medical Insurance Co.	Policy #	Group #
Additional Vision or Health Insurance	Policy #	Group #

PLEASE NOTE: Insurance may cover part of your charges. We will bill your insurance company for you; however, if for any reason your insurance does not cover the amount due in full, you will be billed for outstanding balances and/or copays.

Professional Services are payable when rendered.
Deposit is required on all material orders. Balance in full is due upon delivery.

Signature _____ Date _____

Medicare Patients Only - Authorization to bill Medicare

I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for covered Medicare services to the physician or organization to submit to Medicare for payment to me. I request that payment under the medical insurance program be made either to me or,

Doctor's Name _____ Patient's signature _____

Medicare # _____ Date Signed _____