Family Eyecare Center Doctor of Optometry Patient Registration Record

Patient's Name: _____ Date of Birth: _____/____/_____
Address: _____State of Birth_____ Age: _____
City/State/Zip Code: _____Mother's Maiden Name_____
Home Phone: ( ) _____ Business/Daytime Phone: ( ) _____
Social Security Number: _____ Email Address: _____
Occupation: _____Hobbies: _____
Person responsible for payment if different than patient: _____

_____
Name Address Daytime and Home Phone

Vision Insurance:

Medicare No☐ Yes☐ ID Number: _____
VSP No☐ Yes☐ ID Number: _____
Other: ID Number: _____
Do not have vision insurance ☐
Method of Payment: Cash ☐ Check ☐ Credit Card ☐

Do you or anyone in your family have a history of any of the following? Please state the relationship to the patient. (e.g.: self, mother, father, grandmother, grandfather, etc.)

☐Hypertension_____
☐Diabetes_____
☐Allergies_____
☐Thyroid Disease_____
☐Arthritis_____
☐Other_____
☐ Blindness_____
☐Eye Operations_____
☐Cataract_____
☐Sleep Apnea_____
☐Glaucoma_____
☐Raynaud's Syndrome_____

Please list any medications you are presently taking: _____
_____
Are you allergic to any medications? _____
Do you use cigarettes/tobacco? _____ Alcohol? _____ Other substance(s)? _____
What is the nature of this visit? _____
Your primary care physician is _____
Your previous eye practitioner was _____OD☐ MD☐
When was your last eye exam? _____ years ago.
In case of an emergency, please contact:

_____
Name Relation Address Daytime Phone

Referral: ☐ Insurance list ☐ Search Engine ☐ Signage ☐ Friend/Relative_____

Assignment of Benefits/Financial Agreement

I hereby give authorization for payment of insurance benefits to be made to John J. Riggs, O.D. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, 0.833 % per month interest, and reasonable attorney's fees. If an account is sent to a collection agency, the fee will be 30% of the charge owed and will be added to the total amount due. All fees are due and payable at the time of service unless otherwise agreed upon. No records or prescriptions will be released until payment in full is received. I hereby authorize this healthcare provider to release all information necessary to secure all payment of benefits. I understand that replacement of a frame(s) under warranty is subject to a shipping/handling fee. **I understand and agree that if I or any member of my family miss a scheduled appointment and am not able to cancel with at least 24 hours notice that I will be billed.** I further agree that a photocopy of this agreement shall be as valid as the original.

Signature: _____ Date: _____