PATIENT REGISTRATION FORM **Date:** _____

PATIENT INFORMATION

Last Name	First	MI	Female ( ) Male ( )	Birth Date	Age	Cell Phone
Address			City	State		Zip
SS#		Email				
Occupation		Employer				
School		Grade	Teacher			
Emergency Contact		Relationship		Phone#		
How did you find out about our office?						

Please provide the following: Insurance Card ☐ Driver's License ☐

INSURANCE

Primary Insurance-Name & Address		
Policy#	Group#	Effective Date
Policy Holder Name	DOB (if other than patient)	SS# (if other than patient)
Relationship to Patient		
Secondary Insurance-Name & Address		
Policy#	Group#	Effective Date
Policy Holder Name	DOB (if other than patient)	SS# (if other than patient)
Relationship to Patient		

The patient, legal guardian, or health care surrogate authorizes Professional Eye Care, Inc., dba Outreach Vision to examine the eyes and treat, if necessary, the patient listed above. I understand that consent may be withdrawn at any time in writing to:
PO Box 1008, Platte City, MO 64079-1008.

I request that payment of authorized Medicare benefits be made to Professional Eye Care, Inc. I authorize any holder of medical information to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I request that payment of authorized Medicare Supplemental Insurance benefits be made to Professional Eye Care, Inc.

By signing this document, I acknowledge that the HIPPA notice of privacy practices has been made available to me and I understand that it is available to download and view at www.outreachvision.com.

Patient Signature: _____ Date: _____