

Welcome to OPTICS PLUS

PATIENT REGISTRATION

PATIENT INFORMATION:

NAME _____ TELEPHONE _____
(LAST) (FIRST) (M.I.)
ADDRESS _____ DATE OF BIRTH _____
(STREET)

(CITY) (STATE) (ZIP)

RESPONSIBLE PARTY: If different from above.

NAME _____ TELEPHONE _____
(LAST) (FIRST) (M.I.)
ADDRESS _____ DATE OF BIRTH _____
(STREET)

(CITY) (STATE) (ZIP)
RELATIONSHIP TO INSURED: _____

DO YOU CURRENTLY WEAR CORRECTIVE EYEWEAR?

YES / NO

If Yes, please check all that apply.

- EYEGLASSES Distance Vision Reading Multifocal
 CONTACT LENSES Distance Vision Reading Multifocal

APPROXIMATELY WHEN WAS YOUR LAST EYE EXAM?

DOCTOR'S NAME: _____

CITY, STATE, PHONE _____

INSURANCE / VISION CARE COVERAGE

Name of Insurance: _____ ID No.: _____
Subscriber Name: _____ Relationship: _____
Secondary Insurer (if any) _____ ID No.: _____

WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE

- Doctor Recommendation Name: _____
 Patient Recommendation Name: _____
 Insurance Plan Participation Name: _____
 Advertisement / Mailer
 Internet
 Location

MAY WE CONTACT YOU BY E-MAIL? NOTE: Information will NOT be shared with any outside parties

YES / NO

E-MAIL ADDRESS: _____

DO YOU HAVE HEALTH INSURANCE / VISION CARE COVERAGE

Name of Insurance: _____ ID No.: _____
Subscriber Name: _____ Relationship: _____
Secondary Insurer (if any) _____ ID No.: _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE:

I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of benefits either to myself or to the party who accepts assignment. I understand that I am responsible for any balance due for services and/or products that are deemed "not covered" or denied or delayed (over 60 days) by my benefit plan.

SIGNATURE: _____

DATE: _____

RELATIONSHIP TO PATIENT IF OTHER THAN SELF: _____