PROVISION EYE CENTER REGISTRATION

Date:_____

Name:_____
Last First Middle
Address:_____

City:_____State:_____Zip:_____

Phone(H):_____(W)_____(Cell)_____

Northern Address:_____

City:_____State:_____Zip:_____

Email Address: _____Employer: _____

Race: White __ Hispanic __ Other __ Ethnicity: Caucasian __ Hispanic __ Other __

Sex M F Single __ Married __ Widowed __ Primary Language: _____

Social Security #:_____Date of Birth:_____

Spouse:_____

Social Security #_____Date of Birth:_____

If minor, who is responsible for bill?_____

Address:_____City:_____Zip:_____

Social Security #:_____Date of Birth:_____

Whom may we thank for referring you:_____

Primary Insurance:_____

Secondary Insurance:_____

Contact in case of emergency:_____Phone:_____

I consent to treatment, diagnostic, and/or therapeutic services ordered by Provision Eye Center. I authorize payment by my insurance company/companies on my behalf for services provided. I certify the information given by me under Title XVIII of the Social Security Act is accurate. I understand I am responsible for any unpaid balance including deductibles, co-pays, and any non-covered services.

_____ _____
Patient Signature or Responsible Party Date