VANTAGE
EYE CENTER

PATIENT REGISTRATION FORM

Personal Information

(PLEASE PRINT)

Date _____

Name _____ Wishes to be called _____

Soc. Sec. # _____ Date of Birth _____

☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Race _____ Ethnicity _____ Preferred language _____

Address _____

City, State, Zip _____

Employer _____ Occupation _____

E-Mail _____ Referred by _____

COMPLETE IF PATIENT IS LESS THAN 18 YEARS OR A FULL-TIME STUDENT:

Father's Name _____ Daytime Phone # _____

Mother's Name _____ Daytime Phone # _____

Telephone

Home Phone _____ Cell Phone _____

Work Phone _____ Ext. # _____

Where do you prefer to receive calls? ☐ Home ☐ Work ☐ Cell

In the event of an emergency, who should we contact?

Name _____ Relationship _____ Cell # _____ Home # _____

Insurance Information

PRIMARY

Subscriber's Name _____

Relationship to patient _____

Subscriber's Birth date _____

Soc. Sec. # _____

Employer _____

Occupation _____

Insurance Company _____

SECONDARY

Subscriber's Name _____

Relationship to patient _____

Subscriber's Birth date _____

Soc. Sec. # _____

Employer _____

Occupation _____

Insurance Company _____

Financial Assignment and Insurance Authorization:

I AUTHORIZE PAYMENT OF INSURANCE BENEFITS TO VANTAGE EYE CENTER FOR PROFESSIONAL SERVICES RENDERED. I AUTHORIZE RELEASE OF ANY OR ALL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PAY FOR ALL CO-PAYMENTS, CO-INSURANCE, DEDUCTIBLES, AND ANY SERVICES NOT COVERED BY MY INSURANCE AT THE TIME OF SERVICE. I AM AWARE THAT ALL ACCOUNT BALANCES OVER 60 DAYS MAY INCUR A MONTHLY FINANCIAL CHARGE OF 1.5% (18% APR).

SIGNATURE _____ **DATE** _____

POS Reorder # 1320440