Byers Eye Care | Registration

PATIENT INFORMATION

Full Name_____ Date of Birth_____

Preferred Name_____ ◯ Male ◯ Female SSN_____

Parent / Guardian Name (if minor)_____

Address_____

City_____ State_____ Zip_____

Primary Phone_____ Alternate Phone_____

EMERGENCY CONTACT INFORMATION

Name_____ Relationship to Patient_____ Phone_____

INSURANCE HOLDER

Name of Subscriber_____ Date of Birth_____

SSN_____ Relationship to Patient_____

Insurance Name_____ ID Number_____

Employer_____

SECONDARY INSURANCE HOLDER

Name of Subscriber_____ Date of Birth_____

SSN_____ Relationship to Insured_____

Insurance Name_____ ID Number_____

Employer_____

Permission to Treat	I give Byers Eye Care and its optometrist permission to examine, diagnose, and treat as necessary myself or the minor on this sheet.
Signature on File Authorization	I request and authorize that payments made by Medicare or other insurance companies be made to Byers Eye Care on my behalf for any services provided to me by Byers Eye Care or its optometrist.
Responsibility Statement	I further understand that I am responsible for the entire bill for services provided even though insurance has been filed on my behalf. Insurance is filed as a courtesy to our patients and every effort will be made to verify benefits prior to being seen. Insurance co-payments and/or deductible are due at the time of service. I assume responsibility for all fees that are incurred if my account requires collections or an attorney.
Release of Information	I give permission to Byers Eye Care to **release all medical and financial information** related to this registration **to the following entities**: 1: _____ 2: _____ 3: _____ 4: _____
Privacy Policy	I have reviewed and been offered a copy of the privacy policies of Byers Eye Care.

Signature (Parent or Guardian if under 18)_____ **Date**_____