

# Mayers Eye Solutions - Registration Form

## Patient Information -- Please circle the best way to contact you: Home Phone or Cell Phone

Exam Date to be seen: \_\_\_\_\_ Date and Location of Last Eye Exam: \_\_\_\_\_

Please Check One: Dr. ( ) Mr. ( ) Mrs. ( ) Ms. ( ) Miss ( ) Male ( ) Female ( )

Patient Name: \_\_\_\_\_ Nickname \_\_\_\_\_ SSN: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ Occupation: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Marital Status: Single ( ) Married ( ) Widowed ( ) Divorced ( ) Number of Dependents \_\_\_\_\_

Spouse's Name (if applicable): \_\_\_\_\_ Children's Name (if applicable): \_\_\_\_\_

## Medical Insurance Information -- If same as above, write "same."

Do you have: Medicare ( ) Medicaid ( ) Other Medical Insurance ( ) \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Person Responsible for Bill (if different than patient): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Address(if different than patient): \_\_\_\_\_

Family Physician: \_\_\_\_\_ Date Last Seen: \_\_\_\_\_

Physician's Phone and Address: (if known) \_\_\_\_\_

Do you have vision insurance? If so please specify: \_\_\_\_\_

I understand that I am fully responsible for any charges not covered under my insurance policy. This includes any extra items or materials purchased that are not a benefit of my plan. Any and all charges will be payable to Mayers Eye Solutions LLC.

Patient / Guardian Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

## Office Information

How did you hear about our office and whom may we thank? Referred by \_\_\_\_\_ Other: \_\_\_\_\_

## HIPPA Information

Acknowledgement of Receipt: I acknowledge that I have reviewed a copy of Mayers Eye Solutions HIPPA Privacy Practices.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_