

Patient:

DOB:

Date:

ADULT REGISTRATION FORM (18 years of age and older)

Address _____ apt # _____ City _____ State _____ Zip _____

() _____

() _____

Home phone _____

Cell or alternate phone _____

OK to leave message on phone? Yes No

SELF: Name _____ date of birth _____ / /

Spouse: Name _____ date of birth _____ / /

E-mail _____

Employer _____

Employer _____

Medical Insurance

PRIMARY Insurance Company _____ Subscriber Name _____

Subscriber address (if different from above) _____

Subscriber's birthdate ____/____/____ (required for insurance billing)

SECONDARY Insurance Company _____ Subscriber Name _____

Subscriber's birthdate ____/____/____ (required for insurance billing)

Vision Insurance

VSP Yes No Subscribers last 4 digits of ss# _____ Davis Vision Yes No ID _____

Primary Care Doctor _____ phone _____

Referring Doctor _____ phone _____

Practice name _____

Practice name _____

Office visit claims are submitted to insurance companies based solely on the diagnosis and exam performed by the physician. We cannot change billing for the purpose of maximizing insurance payment and/or minimizing patient financial responsibility. I hereby authorize the release of any medical or other information necessary to process insurance claims billed on my behalf. I also authorize payment directly to the doctor for any benefits available under my insurance plan. I am financially responsible for any non-covered charges and charges incurred by a collection agency in collecting any unpaid balances. Should the account be referred for collections, the undersigned, or their agent will be responsible for payment of collection fees, and court costs. **There is a \$25.00 fee for appointments not cancelled within 24 hours prior to the appointment.**

Signature of responsible party _____ date

Acknowledgement of Notice of Privacy Practices - Our Notice of Privacy Practices provides information about how we may use and disclose the medical information that we maintain about you. It also explains how you can access this information. By signing, you acknowledge that you have reviewed the Notice of Proliance Surgeons, Inc., P.S.

Signature of responsible party _____ date