Patient:

DOB:

Date:

The Children and Family Eye Doctors

ADULT REGISTRATION FORM (19 years of age and older)

Address apt # City State Zip

( ) cell / home / work

Primary phone

Email address

/ /

SELF: Name/Social Security # date of birth

/ /

Spouse: Name/Social Security # date of birth

Employer

Employer

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)

VSP ☐ Yes ☐ No Subscribers last 4 digits of ss# _____

Primary Care Doctor phone

Referring Doctor phone

address

address

Office visit claims are submitted to insurance companies based soley 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 understand that 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, reasonable attorney 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