TIMOTHY C. WISE, O.D.

DATE ______________________

PATIENT REGISTRATION INFORMATION

Welcome to our office! Thank you for choosing our office for your eye care. Please take the time to complete this form accurately and completely. It helps us do the best job possible for you. This information is held in complete confidence as it is part of your permanent record, and will not be released to anyone unless you authorize its release in writing.

Preferred Salutation
Dr. Mr. Mrs. Ms. Miss Reverend **DRIVER'S LICENSE #:** ______________________

Last | First | Preferred Name | Birth Date | Age

Social Security Number | Marital Status | Spouse's Name

Mailing Address | City | State | Zip Code

Residence Phone | Business Phone | Extension | Employer | Occupation

Responsible Party (if different than above) | Address | City | State | Zip Code

How did you hear about us? | Date of Last Eye Exam | Previous Eye Doctor (City & State also)

INSURANCE INFORMATION

We REQUIRE all insurance information prior to services being provided. Due to the diverse nature of many eye conditions, disorders, and procedures, many of the services we provide a re covered by your MAJOR MEDICAL INSURANCE rather than routine vision coverage. Please provide us with the following information even if you believe that you are seeing us for a nonmedical reason. We also require your PRIMARY CARE PHYSICIAN'S NAME & PHONE NUMBER.

MEDICAL INSURANCE COMPANY | Policy Holder | SS# | Primary Care Physician | Phone

VISION INSURANCE COMPANY | Policy Holder | SS# | Policy # | Group #

FINANCIAL POLICY INFORMATION

Please indicate method of payment: ( ) Cash/Check ( )Visa/Master Card

ALL CO-PAYMENTS AND INDIVIDUAL PORTIONS OF YOUR BALANCE ARE DUE AT THE TIME OF SERVICE.

I authorize the release of any medical or other information necessary to process any claims arising from services and materials provided. I also request payment of government or private insurance benefits to the physician accepting assignment for services and materials provided. I also understand that I assume all financial responsibility for this account for any amounts due, regardless of insurance coverage.

Signature | Date | Relationship to Patient