Dr. Pattersons's Family Eyecare
1300 South Canfield Niles Rd
Austintown, OH 44515

PATIENT REGISTRATION

PERSONAL INFORMATION

SS#_____-_____-_____ DOB:_____/_____/_____ AGE:_____ SEX: ☐ Male ☐ Female

PATIENT NAME:_____
Last First MI

MAILING ADDR:_____
Street City State Zip Code

HOME PH: (____)_____ DAYTIME PH: (____)_____ CELL PH: (____)_____

E-MAIL ADDRESS: _____

WORK PH: (____)_____ EMPLOYER:_____OCCUPATION:_____

EMERGENCY INFORMATION

CONTACT
NAME:_____PHONE:_____

FAMILY DOCTOR

FAMILY DOCTOR:_____ PHONE: (____)_____ CITY / STATE / ZIP: _____

INSURANCE IMFORMATION

PRIMARY INSURANCE (VISION OR MEDICAL)_____
SUBCRIBER NAME_____ SUBSCRIBER DOB_____
ID# or POLICY # _____ GROUP #_____

SECONDARY INSURANCE (VISION OR MEDICAL)_____
SUBSCRIBER NAME_____ SUBSCRIBER DOB_____
ID# or POLICY # _____ GROUP #_____

ASSIGNMENT OF BENEFITS/INSURANCE DISCLAIMER: I hereby irrevocably authorize my insurance company(s) or fund to make payment directly to Dr. Patterson's Family Eyecare of any insurance benefits otherwise payable to me, for professional services and/or materials rendered to date, but not to exceed the stated charges for these services. I understand that I am responsible for any charges not paid by my insurance company, and for any charges not paid within sixty (60) days of billing to said insurance company. Patterson's Family Eyecare is not responsible if your insurance company does not pay for your professional services and materials. You are financially responsible for non-covered services and/or materials. By signing this form, I give Dr. Patterson's Family Eyecare the right to bill my insurance company, and to use this form as my "signature on file". A copy of this authorization shall be valid as the original.

RELEASE OF INFORMATION: I hereby authorize Dr. Patterson's Family Eyecare to furnish and disclose all known facts concerning my care to my insurance company(s) or fund, and to other Optometrist or Physician as deemed necessary to provide for my care. A copy of this authorization shall be valid as the original.

X_____ X_____
SIGNATURE: PATIENT / LEGAL GUARDIAN (if under 18) **DATE**