Patient Registration Form

MUST BE UPDATED AT EACH VISIT

Today's Date:_____ Are you a new patient? YES NO

Last Name: _____ First Name:_____ Middle Initial_____

Address _____ City _____ State _____ Zip Code _____

Home #: _____ Work#:_____ Cell #:_____

Email: _____ Date of Birth___/___/_____ Age _____ Sex: M F

Referred By? Dr._____ Clinic _____ Friend/Family_____ Website

HISTORY QUESTIONARY

What kind of work / occupation or hobbies do you do?_____

Do you have?

Diabetes	YES	NO
High Blood Pressure	YES	NO
High Cholesterol	YES	NO

Do you wear prescribed glasses now or have you been prescribed glasses in the past? YES NO

Today's Examination is for:

Prescription glasses / Regular Vision Exam	YES	NO
Contact Lens Fit or prescription Renewal	YES	NO
Eye Health Exam (ex., injury, red eye, allergies...)	YES	NO

INSURANCE AND PAYMENT AUTHORIZATION

VISION INSURANCE

Plan Name: _____ Policyholder's Name:_____

Policyholder's Social Security #:_____ Policyholder's Date of Birth ___/___/_____

HEALTH INSURANCE

Plan Name: _____ Policyholder's Name:_____

Policyholder's Social Security#: _____ Policyholder's Date of Birth ___/___/_____

Medi-Cal/Medicaid

ID:_____ Plan Name:_____ Issue Date: _____

MediCare

ID:_____ Plan Name:_____

INSURANCE INFORMATION / RESPONSIBILITY AGREEMENT

I request that payment of authorized insurance benefits be made on my behalf to Shermin Lahijani O.D. I authorize the release of information necessary to process claims. I permit my signature to be kept on file for future visits and insurance filings. Due to the varying nature of vision and health insurance company plans, there may be additional fees or eligibility denials that my insurance dictates at the time of filing my insurance by the Shermin Lahijani O.D. I understand and agree that regardless of my insurance benefits, I (or my guarantor) am responsible to pay for the balance on my account for all professional services and materials provided. I understand that if payment is not made in a timely manner, I may incur late or collection fees on all overdue balances on my account.

Signature _____ Date___/___/_____

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I have received and read a copy of the Patient Information Privacy Policy. I hereby authorize Shermin Lahijani O.D to release any of my or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

Signature : _____ Date:_____/___/_____