Welcome to Sandia Vision Clinic

Patient Registration Information

Date_____
Last Name_____ First_____ Mid. Int._____
Title: [ ] Mrs. [ ] Ms. [ ] Mr. [ ] Other_____
Address_____
City _____ State _____ Zip _____
Home Tel.# ( ) _____ Soc. Sec. #_____
Birthdate _____- _____- _____
Occupation_____ Employer_____
Work Tel.# ( ) _____ Ext.#_____
How were you referred to our office? [ ] Vision Plan [ ] Location [ ] Friend [ ] Yellow Pages
Person who referred you to our office_____

Person Responsible For Payment

Last Name_____ First _____ Mid. Int. _____
Title: [ ] Mrs. [ ] Ms. [ ] Mr. [ ] Other _____SS#_____
Relationship to Patient _____
Address_____
City _____ State_____ Zip _____
Home Tel.# ( ) _____ Work Tel.# ( ) _____
Employer_____ Occupation_____
How do you plan to pay? [ ] Check [ ] Cash [ ] Credit Card

Insurance Information

Vision Plan: [ ] Vision Service Plan (VSP) [ ] Superior Vision [ ] Davis Vision
[ ] Eye Care Plan of America/Eyemed
Medical Plan: Subscriber name:_____
DOB:_____
Insurance Name:_____ Insurance
ID#_____
Group
Name:_____

Assignment and Release

I hereby authorize payment directly to Dr. _____ all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, for all services rendered on my behalf or my dependents

I authorize the above noted provider and/or any provider or supplier of services in this office to release any information required to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party_____ Date_____