

PATIENT REGISTRATION

PLEASE PRINT and be sure to complete the entire form and bring with you to your eye exam.

Last Name		First Name	Middle Name	
Email Address		Date of Birth	Age	Sex
Home Address	Street	City	State	Zip Code
Home Telephone		Cell Telephone	Business Telephone	
Employer		Occupation		

RESPONSIBLE PARTY – Please indicate the person listed as the policyholder and / or who will be responsible for the bill (spouse, parent, etc.).

Name of Insured / Responsible Party		Address (if different from above)	City	State	Zip
Home Telephone		Cell Telephone	Business Telephone		
Relationship to patient		Date of Birth			

VISION INSURANCE INFORMATION

Name of Insurance Carrier:		Vision Service Plan (VSP)
Insured Employee / Member Name		Member ID Number
Name of Group Insured (Employer)		Employer Telephone

I hereby authorize payment directly to Ousley Vision Center by my insurance company, for any services or materials incurred on behalf of my family or myself. I also authorize release of any information regarding the history, treatment or benefits payable concerning claims made to my insurance company. I understand that any and all charges not covered by my insurance company are my personal responsibility, included by not limited to co-payments and deductibles. Copies of these signatures shall be as valid as the originals.

Print Patient Name	Patient Signature	Date
Print Insured's Name	Insured's / Responsible Party Signature	Date