

PATIENT REGISTRATION

Patient Name _____ Social Security # _____
Street Address _____ City, State _____ Zip _____
Phone # Home: _____ Cell: _____ Date of Birth ____/____/____
Employer/Work Phone # _____ Occupation _____
Emergency Contact/Phone # _____
"Family Doctor" _____ Spouse/Parent _____

Medical Insurance: BCBS ____ Medicare ____ Other _____
Vision Insurance: VSP ____ MEBS ____ B CBS ____ Other _____
Insurance Information (If different from above):
Member's Name _____ Member's Social Security # _____
Member's Date of Birth ____/____/____

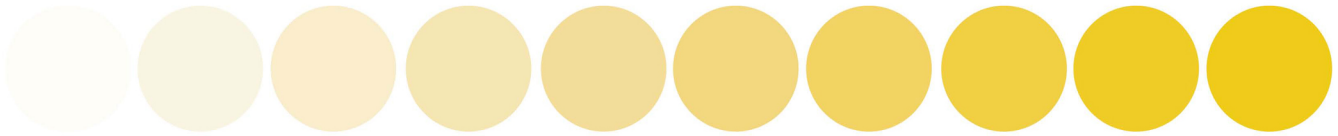
How did you hear about our office? Please check one:

Friend ____ (name) _____
Phone Book ____ Radio ____ Insurance Listing ____ Internet ____
Doctor Referral ____ Doctor's Name _____
Other ____ (Explain) _____

I authorize any holder of medical or other information about me to be released to the Social Security Administration or insurance carrier. This would include payment information for related claims. I permit a copy of this authorization to be used in place of the original to request payment. I understand that I am personally responsible for payment of services or materials not covered by Medicare or other insurances. I also give permission to release information to my physician, any physicians we refer you to, and/or my family

Signature/Guardian's Signature _____ Date _____

Niles Vision Clinic



Notice of Acknowledgment

Acknowledgment:

I acknowledge that I have been made aware of the public location of the Notice of Privacy Practices within the reception areas of Niles Vision Clinic and/or have received a copy of the Notice of Privacy Practices.

Patient or Personal Representative

Date

If Personal Representative's signature appears, please describe Personal Representative's relationship to the patient.