WELCOME TO OUR OFFICE

I Care Vision Centers

Patient Registration Form

Patient Name: _____
First MI Last

Parent or Guardian Name: _____
First MI Last

Address: _____
Street Apt. City Zip

Phone Number: _____
Home Daytime

Patient Birthdate: _____ Patient SS#: _____

Name of Vision Insurance Plan: _____

Name of Insurance Plan Member: _____
First MI Last

Employer of Member: _____ Member ID#: _____

Referred By: _____ email address: _____

I acknowledge that all of the above information is correct and current. I hereby authorize the physician to release any information required to process any claims. I also authorize my insurance benefits to be paid directly to the physician and I understand that I am financially responsible for all non-covered services.

_____ _____
Signature of Patient or Guardian Date

_____ _____
Signature of Patient or Guardian Date

_____ _____
Signature of Patient or Guardian Date

_____ _____
Signature of Patient or Guardian Date

_____ _____
Signature of Patient or Guardian Date

Please List Any Changes Below: Date: _____

Name: _____

Address: _____

Phone Numbers: _____

Insurance Plan: _____

Employer: _____