

NASHVILLE VISION ASSOCIATES PATIENT REGISTRATION FORM

Mr. Mrs. Miss Ms. _____ Home phone: _____

Address: _____ Work phone: _____

City: _____ State: _____ Zip: _____ Mobile phone: _____

Date of Birth: _____ - _____ - _____ Age: _____ Sex: Female Male

Social Security #: _____ - _____ - _____ Marital Status: Single Married Divorced Widowed

Patient's Employer: _____ Occupation: _____

Spouse's Name: _____ Spouse's Work Phone #: _____

EMERGENCY CONTACT: _____ Phone #: _____
(Must list someone) (other than phone listed above)

Relationship to patient: _____

Primary Care Physician: _____ Physician's Phone #: _____

How were you referred to our office? _____

If patient is under the age of 18, please indicate who is responsible for payment:

Name _____ Relationship to Patient: _____

Address: _____
(if different from above)

City: _____ State: _____ Zip code: _____ Phone : _____

We will scan/copy your insurance cards. Please tell us the order of filing below:

1st Insurance Co. _____ Insured name _____ DOB _____

2nd Insurance Co. _____ Insured name _____ DOB _____

3rd Insurance Co. _____ Insured name _____ DOB _____

I understand and agree that *(regardless of my insurance status)* I am ultimately responsible for the balance of my account for any professional services rendered *(refrctions, co-pays, deductibles, non-covered services, etc.)* I have read all the information, and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or in any of the above information. I authorize the release of any medical information necessary to process all claims. I also authorize the release of payment for medical benefits to my physician.

Patient's Signature _____ Date: _____

If Patient is Minor, Parent 's Signature _____ Date: _____