Welcome to Our Office

For faster service, please complete this form before you arrive.

Last name_____ First Name_____ MI_____ Date of Birth_____ M or F_____

Address 1_____ City. State. Zip: _____

Address 2_____ City, State, Zip: _____

Home Phone; _____ Work Phone: _____ Ext: _____ Cellular: _____

E-mail: _____ [ ] I would like to receive correspondences via [ ] text or [ ] e-mail.

Soc Sec: _____ Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed

Drivers Lic: _____ Employer: _____ Occupation: _____

Employment Status: [ ] Full Time [ ] Part Time [ ] Other Student Status: [ ] Full Time [ ] Part Time

How did you hear about our office? [ ] Saw the office [ ] From a friend [ ] Yellow Pages [ ] News Paper [ ] Internet [ ] Family [ ] Insurance [ ] I'm a previous patient [ ] Referral

Vision Plan----------

Plan: _____ Policy ID# _____ Relationship to insured [ ] Self [ ] Spouse [}Child [ ] Other

Medical Insurance----------

Primary Insured Name_____ Insured SSN_____ Insured DOB _____

Insurance Plan Name: _____ Policy/Group # _____

Relationship [ ] Self [ ] Spouse [ ] Child [ ] Other ID#_____

Secondary Insured Name_____ Insured SSN_____ Insured DOB _____

Insurance Plan Name: _____ Policy/Group # _____

Relationship [ ] Self [ ] Spouse [ ] Child [ ] Other ID#_____

I understand that I am responsible for the payment of all services rendered by Dr. Register and Beach Vision, whether or not they are covered by insurance. I also understand that payment is due at the time services are rendered. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all of my insurance submissions.

Signature of insured/guardian _____ Date _____

Lifetime Insurance Authorization for Medicare, Accepted Major Medical Plans, and Vision Plans

I request that payment of authorized Primary and Supplementary Insurance benefits be made either to me or on my behalf to Dr. Register for services rendered at Beach Vision. I authorize the holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

Signature of insured/guardian_____Date_____

Our office accepts cash, checks, Visa, Mastercard, American Express, Discover and Debit Cards.

Accepted insurance plans include VSP, Humana VCP, Eyemed, Medsave USA, Medicare, Blue Cross Blue Shield, and many Major Medical plans. Please ask if yours is not listed.