INGLEWOOD
OPTOMETRIC CENTER

Registration Form

Patient Name: _____ DOB: _____ / _____ /_____

Address: _____

City_____ State _____ Zip: _____ SSN:_____

Home Phone: (_____) _____-_____ Cell: (_____) _____-_____ Work Phone: (_____) _____-_____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Unmarried E-Mail Address: _____

Employer: _____ Job Title: _____

Name of Emergency Contact:_____ Phone: (_____) _____-_____ Relation: _____

Primary Care Physician / Phone: _____ / (____) _____-_____

Insurance Information

Vision Insurance: ☐ No ☐ Yes *if yes, name of vision insurance.* _____

Preferred method to contact you: ☐ Email ☐ Text Cell ☐ Phone

How did you learn about our office? ○ Another Doctor ○ Another Patient ○ Advertisement ○ Insurance Company ○ Our Office Website ○ Insurance Website

When was your last eye examination? _____

Previous Eye Doctor?_____

I hereby authorize Inglewood Optometric Center to treat me. Payments and co-payments for services rendered are due on the same day of service. As part of our services we will submit your insurance claims. I understand that if my insurance carrier denies benefits or fails to pay for benefits that I am ultimately responsible. A 50% deposit is needed for all eyeglass and contact lens orders. All materials not picked up within 90 days will return to stock and 25% of your deposit will be nonrefundable.

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS DECLARATION:

I hereby authorize release of any medical information necessary to process my insurance claim and a lso ASSIGN to the DOCTOR all payments from MEDICARE and/or other insurance provider(s) for services rendered. I understand and agree to the above conditions.

HIPAA PRIVACY RIGHTS AND AUTHORIZATION FOR DISCLOSURE OR PROTECTED HEALTH INFORMATION:

I have read the HIPAA rights and authorization statements and give my consent for disclosure of my medical records related to treatment.

By signing below I am stating that I understand this policy.

DATE: _____/_____ / _____ SIGNATURE_____: