Dr. Jeffrey A. Poland
Dr. John A. Manard
Dr. Samantha R. Kessler
Diagnostic and Therapeutic Optometry

Two Frederick Street Cumberland, Maryland 21502
T. (301) 777-7777 ▪ (800) 858-4777 F. (301) 777-7798
LifetimeEyecareCenter.com

Registration Form

□ Mr. □ Mrs. □ Ms. □ Dr. □ Rev. □ ____ Preferred Name: ___________________________

LAST NAME: ____________________________ FIRST NAME:________________________________ MI:____________

DATE OF BIRTH: ______ /______ /______ SOCIAL SECURITY # _______ - _____ - _______ □ Female □ Male

MAILING ADDRESS: ____

CITY: ____ STATE: _____________ ZIP: ______________________

HOME PHONE : ___________________________CELL: ______________________ WORK: _________________________

Preferred Phone (*circle one*): Home Cell Work

E-MAIL: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

☐ **No E-MAIL** (PLEASE PRINT NEATLY USING A BLOCK FOR EACH LETTER, #, OR CHARACTER)

Your e-mail address will be used only for Lifetime Eyecare communication. We will not share.

EMPLOYER: _____________________________ POSITION/TITLE: ________________ □ Full-Time □ Part-Time

STUDENT: □ Full-Time □ Part-Time □ Retired □ Disabled

GUARANTOR *(Person responsible for your financial account)*: □ **SELF**

□ OTHER *(Name)* :____ Relationship: _____________________________

DATE OF BIRTH: _____ /_____ /_____ SOCIAL SECURITY # _____ - ___ - _____ Phone: ____________________________

Mailing Address: (□ *same as pt)* ____

Please fill out the information below ***<u>IF YOU ARE NOT THE POLICY HOLDER.</u>*** *It is not provided on your insurance card(s)*

PRIMARY MEDICAL INSURANCE: _______________________
Policy Holder Name: ________________________________
DOB: _______________ SSN: _________________________
Relationship to patient: ______________________________
Employer: ____

Secondary Medical Insurance:_____________________
Policy Holder Name: ____________________________
DOB: _______________ SSN: _____________________
Relationship to patient: __________________________
Employer: _______________________________________

PRIMARY VISION INSURANCE: ________________________
Policy Holder Name: ________________________________
DOB: _______________ SSN: _________________________
Relationship to patient: ____________________________
Employer: ____

Secondary Vision Insurance: _______________________
Policy Holder Name: ____________________________
DOB: _______________ SSN: _____________________
Relationship to patient: __________________________
Employer: _______________________________________

<u>Please Read and Sign Below:</u> I certify that the above information is correct to the best of my knowledge. I have provided my most recent and up to date insurance card(s)/information. I authorize Lifetime Eyecare Center to accept payment from my insurance company. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that the final determination of payment can only be made once the claim is processed. Copays, co-insurances, deductibles, non-covered services and any patient balances are due at the time services are rendered. Balances for materials (eyeglasses/contact lenses) are required to be paid in full at the time the order is placed. I further understand that any portion of my visit not paid for by my insurance company is my responsibility and I will be required to pay any additional fees in a timely manner. Overdue accounts will be subject to late fees and submission to a collection agency.

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SIGNATURE Date