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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 IF YOU ARE NOT THE POLICY HOLDER. It is not provided on your insurance card(s)

PRIMARY MEDICAL INSURANCE: Secondary Medical Insurance:

Policy Holder Name:

DOB: SSN:

Relationship to patient:

Employer:

PRIMARY VISION INSURANCE: Secondary Vision Insurance:

Policy Holder Name:

DOB: SSN:

Relationship to patient:

Employer:

Please Read and Sign Below: 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.

SIGNATURE

Date