PATIENT REGISTRATION FORM

Thank you for choosing Family Vision Care for your vision care needs. Please complete this form. If you have any questions or concerns, please do not hesitate to ask for assistance. We will be happy to help.

Name: _____ Date:_____
Last First MI

Address: _____Birthdate: _____/_____/_____ ☐Male ☐Female

City: _____ State: _____ Zip Code: _____ E-Mail: _____

Home Phone #: (____) _____ Work Phone #: (_____) _____ Cell #: (_____) _____

Contact Preference: ☐Home ☐Work ☐Cell ☐Email

Occupation: _____Parent or Guardian Name (if minor):_____

Emergency Contact: _____ Relationship: _____ Phone #:_____

INSURANCE INFORMATION:

(Please give a picture id & all insurance cards to the assistant at the front desk)

Primary MEDICAL Insurance: _____

Primary VISION Insurance: _____

Secondary MEDICAL Insurance: _____

Secondary VISION Insurance: _____

MARKETING INFORMATION

Please tell us how you heard about us (i.e. Yelp, friend etc)?_____

INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Kibert Kato, O.D. or Family Vision Care, Inc. on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Center for Medicare & Medicaid Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the CMS-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

I authorize the staff of Family Vision Care, Inc. to administer such treatments as reasonable or may be necessary in connection with the condition for which I or members of my family have sought care. To the extent necessary to determine the liability for payments and to obtain reimbursement, I hereby authorize Kibert T. Kato O.D. and the staff of Family Vision Care, Inc. to apply for benefits on my behalf for covered services rendered by them. I also request that all payments from the agreed third party be made directly to Family Vision Care, Inc. or Kibert T Kato O.D. I agree to assume responsibility of full payment pending my remaining balance that is not covered by the agreed third party. I certify the information I have reported on my insurance coverage is current and correct. I understand I am responsible for my own bill.

I understand payment is due at the time services are rendered.

Signature: _____ Date:_____
(If patient under age 18, signature of parent or legal guardian required)