EYE CARE OF IOWA

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Name: _____ MI: _____

Social Security # _____-_____-_____ Birth Date: ____/____/_____ Age: _____ Sex: Male Female

Marital Status: Single Married Divorced Widowed

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ May we text you? YES NO

Daytime Phone: _____ Email: _____

Employer: _____ Occupation: _____

Race: American Indian/ Alaska Native Asian Black/African American Hispanic Native Hawaiian/ other Pacific Island White

Ethnicity: Hispanic/Latino Not Hispanic/Latino Native Hawaiian/ other Pacific Island

Insurance Information

(Please give your insurance card to the receptionist)

Primary Insurance Holder: Birth Date: Address: (if different)

_____ _____/_____/_____ _____

Occupation: Employer: Subscriber's SS #

_____ _____ _____-_____-_____

Patient's relationship to subscriber: Self Spouse Child Other Home Phone: (If different): _____

Secondary Insurance Holder (if applicable): Birth Date:

_____ _____/_____/_____

Patient's relationship to subscriber: Self Spouse Child Other

******Co-pays are due at the time of service, unless special arrangements have been made******

Contact lens services are not always covered in full by most insurance plans. Contact lens fees are due at the time of service, our contact lens fitting fees are based upon an evaluation of contact lenses on your eyes, and fees are charged according to the complexity of your prescription and type of contact lenses you need.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize EYE CARE OF IOWA or insurance company to release any information required to process my claims. I also acknowledge that I have received a copy of EYE CARE OF IOWA's Notice of Privacy Practices.

Patient/Guardian Signature: _____ Date: _____

Permission to Release Information:

Your eyeglass and contact lens prescription are protected health information according to HIPAA. If you would like copies of your prescriptions we would be happy to provide them for you in person, at our office. If you think for future purposes that you may require this information and cannot come into the office in person, please sign below.

I authorize the release of my prescription/records to the office of my choice. _____ Date _____