EYE CARE OF IOWA

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Name:_____ MI:_____		Social Security #	_____- _____- _____
Address:_____	City:_____	State:_____	ZIP Code:_____
Home Phone: _____ Daytime Phone:_____	Cell Phone:_____ Email _____	May we text you? ☐ Yes ☐ No	

Birth date: _____	Age: _____	Sex: ☐ M ☐ F	Employer_____FT___PT___ Occupation_____

Marital Status:	☐ Single	☐ Married	☐ Divorced	☐ Widowed

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.)

Responsible Party	Birth date:	Address (if different):			Home phone: ( )
Occupation:	Employer:				
Subscriber's name:	Subscriber's S.S. #:	Birth date:			
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	
Name of secondary insurance (if applicable):	Subscriber's name:				
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	

****CO-PAYS ARE DUE AT THE TIME OF SERVICE, UNLESS SPECIAL ARRANGEMENTS ARE 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 will 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:_____