VISIONMAKERS®
Helping You "C" Better®

PATIENT REGISTRATION

PLEASE PRINT

PATIENT

FIRST NAME	M. I.	NICKNAME	LAST NAME	SEX	STUDENT
				M_____ F_____	Y_____ N_____

STREET ADDRESS	SOCIAL SECURITY NO.	AGE	DATE OF BIRTH (M M D D Y Y)

CITY	STATE	ZIP CODE	HOME PHONE ( )

PATIENT'S RELATIONSHIP TO ENROLLEE	MARITAL STATUS	EMPLOYMENT	WORK PHONE ( )
Self_____ Spouse_____ Dependent/Child_____	Sing____Mar____Div____Wid____	FT____PT____Ret____Unem____	

NAME OF EMPLOYER	ADDRESS OF EMPLOYER

IS PATIENT COVERED BY ANOTHER GROUP VISION PLAN? ____Yes ____No If "Yes", Complete the Following: VISION PLAN NAME UNION LOCAL GROUP# NAME AND ADDRESS OF CARRIER

WAS AN ACCIDENT INVOLVED? ____Yes ____No If "Yes", Was the injured Person at Work When the Accident Happened? ____Yes ____No

HAS CATARACT SURGERY BEEN PERFORMED? ____Yes ____No If Yes: Date _____ Doctor: _____

Falsification or misrepresentation of information requested below may result in action(s) deemed appropriate by Employer and/or insurance.
(Please answer questions on Reverse side before claim is completed)

INSURANCE

FIRST NAME	MIDDLE INITIAL	LAST NAME	SOCIAL SECURITY NO.

STREET ADDRESS	AGE	DATE OF BIRTH (M M D D Y Y)	SEX
			M____ F____

CITY	STATE	ZIP CODE	

NAME OF EMPLOYER	ADDRESS OF EMPLOYER

AUTHORIZATION

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services to the physician OR organization furnishing the services and authorize such physician OR organization to submit a claim to my insurance carrier OR Medicare for payment. I authorize any holder of medical or other information about me to release to insurance carriers OR the Health Care Financing Administration and its agents OR the Social Security Administration or its intermediaries OR any agency, group or person(s) necessary to secure payment any information needed for this or related Medicare claim. *For and in consideration of services rendered and to be rendered by the above listed medical provider, I hereby guarantee payment of all charges incurred for this account. *The patient or his/her representative recognizing the need for health care, consents to the above listed medical provider rendering services as ordered by the physicians, including medical or surgical treatment, laboratory procedures, X-ray examinations or other services rendered under the general and specific instructions of the physicians. *I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.

DATE_____ SIGNATURE X_____
PATIENT (PARENT/GUARDIAN IF MINOR)