Collin Creek Eye Clinic
REGISTRATION FORM

PATIENT INFORMATION

Patient's last name: First: Middle Int: Today's Date:

Marital status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

Birth date: Age: Sex: ☐ M ☐ F Social Security No:

Street address:

P.O. box: City: State: ZIP Code:

Daytime Phone: Home Phone: e-mail:

Occupation: Employer: Employer phone no.:

I was referred to Dr. Pattni by (Please check one box): ☐ Dr. ☐ Insurance plan ☐ Hospital

☐ Family ☐ Friend ☐ Close to home/work ☐ Advertising ☐ Other (specify)

Is this patient covered by insurance? ☐ Yes ☐ No (IF YES, PLEASE COMPLETE THE INSURANCE INFORMATION BELOW)

Other family members seen by Dr. Pattni:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Primary insurance carrier information:
☐ Aetna ☐ Great West ☐ Spectera/Optum ☐ Other (specify)
☐ Blue Cross/Blue Shield ☐ Medicare ☐ United Healthcare
☐ Cigna ☐ PHCS ☐ Vision Service Plan (VSP)

Name of secondary insurance (if applicable):

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber's name : (if different from patient) | Social Security#: | Birth date: | Group no.: | Policy no.:

Occupation: | Employer: | Employer address: | Employer phone no.:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: | Work phone no.:

SIGNATURE

1. I understand that providing incorrect information can be dangerous to my health.
2. The use of cellular phones is not permitted in the exam room Please turn them off during the exam.
3. For all managed care vision plans including Aetna, Cigna, Davis, Metlife, Prudential, Spectera, Superior Vision Total Vision and VSP, any visits regarding medical diagnosis, prescription rechecks or consultation will be the patients responsibility and payment will be expected at the time of service.
4. I understand that my vision insurance carrier may pay less than the actual bill for services. I also understand that it may not cover medical diagnosis related to visual disturbances. I agree to be responsible for payment of all services and materials rendered on my behalf or my dependents.
5. There is a 30% non refundable restocking fee for any cancellations of spectacles or contact lenses prior to dispensing. A warranty fee will be charged for all warranty items.
6. Professional fees are non-refundable under any circumstances.
7. I agree to arbitrate any disagreement, controversy or claim which cannot be otherwise resolved to my satisfaction arising out of or relating to any services provided by Collin Creek Eye Clinic and to settle any dispute by arbitration in accordance with the rules of the American Arbitration Association which provides dispute resolution services. I have read the Notice of Privacy Policies and agree that Collin Creek Eye Clinic can use and disclose my health information to treat me, obtain payment and perform healthcare operations

I have read and fully understand the information above.

Patient/Guardian signature *Date*