REGISTRATION FORM

Patient Information

NAME_____ DOB_____

ADDRESS_____

HOME PHONE_____CELL PHONE _____ WORK_____

GENDER MALE FEMALE MARITIAL STATUS_____

OCCUPATION _____ EMAIL ADDRESS_____

HOW WERE YOU REFERRED TO OUR OFFICE? _____

EMERGENCY CONTACT NAME_____ PHONE_____

RELATIONSHIP TO PATIENT_____

PHARMACY_____ ADDRESS_____

PRIMARY DOCTOR NAME_____ PHONE_____

OTHER SPECIALIST DOCTOR(S) YOU SEE_____

HEALTH INSURANCE NAME_____

ID #_____

SUBSCRIBER NAME_____ SUBSCRIBER DOB_____

SUBSCRIBER RELATIONSHIP TO PATIENT_____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I the undersigned give my authorization to treat and assign directly to Visionary Ophthalmology and Cataract care, all medical benefits, if, any otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all my insurance submissions. I understand that payment of my copayment, co-insurance, and deductible is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

SIGNATURE_____

Relationship to Patient_____

VISIONARY OPHTHALMOLOGY AND CATARACT CARE

40 NO UNION RD., WILLIAMSVILLE NY 14221

716-634-4441

www.BuffaloVisionary.com

PLEASE BRING PHOTO ID AND ALL INSURANCE CARDS TO YOUR VISIT