PATIENT REGISTRATION FORM

DATE______/______/______

I. General information

Patient's Name: (Mr. / Mrs. / Ms. / Dr.) (Last, First, MI) ____

Address:________________________________City______________________State________ZIP ___________

Home Phone (______)______________Cell Phone (_____)_______________Work Phone (_____)____________________

DOB_____/_____/_______ Gender: [M / F] SSN________-_______-________ Marital Status: [Single / Married /Other]

Parent/Legal Guardian:_____________________________Phone:__________________Alt. Phone:_________________

Emergency Contact______________________________Relationship____________________Phone:__________________

Primary Physician: Dr.____________________________Phone: _____________________Email:______________________

How did you hear about us? ☐ Friend/Family ☐ Internet ☐ Signs ☐ Other:____________________

AS A COURTESY, WE WILL FILE MOST INSURANCE CLAIMS WHEN YOU COMPLETE THE SECTION BELOW AND PROVIDE THE FOLLOWING:

1. **Photocopies of the front and back of your valid insurance ID card.**
2. **Downloaded or printed description of your medical and/or vision benefits.**
3. **Authorization to file insurance claims and receive direct payment for services rendered.**

***Primary Medical Insurance*:**________________________ Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent

Name of Primary Insured:____

Insured's D.O.B.: ______/______/______ **Insured's SSN: SSN**_____-____-_____

Insured's Address____Phone #____________________

Subscriber ID #:_____________________________**Group #:**_______________________

Secondary Medical Insurance:______________________ Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent

Name of Primary Insured:____

Insured's D.O.B.: ______/______/______ **Insured's SSN: SSN**_____-____-_____

Insured's Address____Phone #____________________

Subscriber ID #:_____________________________**Group #:**_______________________

Vision Plan:______________________________________ Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent

Name of Primary Insured:____

Insured's D.O.B.: ______/______/______ **Insured's SSN: SSN**_____-____-_____

Insured's Address____Phone #____________________

Subscriber ID #:_____________________________**Group #:**________________________

INFORMED CONSENT & TREATMENT AUTHORIZATION

- I have read or had explained to me the *Notice of Privacy Practices/HIPAA* for TRINITY VISION CENTER and agree to continue my care with TRINITY VISION CENTER under said terms.
- CONSENT FOR DILATION: In order to thoroughly examine the internal health of the eyes, we may need to place eye drops that enlarge your pupils. Side effects may include temporary blurred near vision and light sensitivity that last approximately 4 to 6 hours. For some individuals the distance vision may also be blurred, needing a separate driver for safety. This procedure is provided at no additional fee and may add 20 – 30 minutes to the complete examination time.
- I hereby authorize TRINITY VISION CENTER to provide a diagnosis & optometric treatment to my child or me. I further authorize the release of Protected Health Information to additional physicians or optometrists in order to facilitate continuity of care. I have read & understand the above information & am signing this form voluntarily.

X____ ________________________________

Patient or Legal Guardian's Signature Date