WILSON EYE ASSOCIATES, OPTOMETRISTS, PA
PATIENT REGISTRATION FORM
Please Print and Complete all Blanks

*****Give ALL Insurance cards to the Front Desk*****

Chart: _____ (office use) Appointment Date: _____

Patient's Full Name: _____ _____ _____

Sex: (please circle) M F Date of Birth: _____ SSN: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ Work Phone: (_____)_____

Cell Phone: (_____)_____, OK to Text? _____ Email: _____

Marital Status: (please circle) Single Married Divorced Widowed DP

Relative or Friend Phone: _____ Name: _____

Are you: (please circle) Employed Retired Student Other

Employer Name: _____

Employer Address City: _____State: _____

Family Physician Name: _____ Last Physical Exam: _____

Last Vision Exam: _____ Name of Eye Doctor who did your exam: _____

******PLEASE GIVE ALL INSURANCE CARDS TO THE FRONT DESK UPON ARRIVAL FOR CORRECT FILING OF YOUR INSURANCE******

Name of Medical Insurance - example: Medicare, Medicaid, BCBS

Primary **Medical** Insurance : _____

Policy Holder's Name: _____ DOB: _____

Policy Holder's SSN: _____ RELATIONSHIP:_____

Primary **Vision** Insurance: _____

Policy Holder's Name: _____ DOB: _____

Policy Holder's SSN: _____ RELATIONSHIP:_____

Secondary **Medical** Insurance : _____

Policy Holder's Name: _____ DOB: _____

Policy Holder's SSN: _____ RELATIONSHIP:_____

Other: _____

Please complete next page →

HIPAA PATIENT CONSENT
Use and Disclosure of Protected Health Information and Acknowledgment of our Notice of Privacy Practice

I hereby give my consent for Wilson Eye Associates, to use and disclose protected health information about me to carry out treatment, payment and health care operations. The Notice of Privacy Practice provided by Wilson Eye Associates, describes such uses and disclosures. The Notice also describes my rights concerning the use and disclosure of my protected health information. I understand that I can file a complaint, if I believe that my information is not being protected or that my rights have been denied.

I have the right to revoke my consent at any time. I understand that should I revoke this consent and limit or restrict the use of disclosure of my information I must describe the restrictions and limitations in writing. I must submit such written restrictions and limitations to the contact person listed in the Notice. I understand that should I revoke my consent that the information already used or disclosed based on my consent can not be reserved.

Wilson Eye Associates has the right to change their Privacy Practice Notice at any time. If Wilson Eye Associates changes their Notice, the new Privacy Practice Notice will apply to all health information that they already have as well as to such information that they may generate in the future.

I have been given the opportunity and encouraged to read the Privacy Practice Notice in the full detail. By signing this Consent, I have agreed to the use and disclosure of my information as described in the Notice without restriction or limitations. This consent also serves as my acknowledgment of reading the Notice and the opportunity to obtain my own copy in full detail. **(Please ask the Front desk to provide you a complete copy of our Privacy Practice Notice if you desire to have a copy for yourself.)**

Patient's Name (please print): _____Today's Date: _____

Signature of Patient or Authorized Agent: _____
Relationship, if other than patient: _____

Important, Please Read:
Please list below the name of any family members, friends or contacts, including the name of your child's school and its employees (if applicable) that we may disclose any information to about you. For children under the age of 18, we must have at least one or both parent's name or Guardians.

Name: _____ Relationship: _____
Name: _____ Relationship: _____

If this patient is a minor and in school, please list the school name and phone number that he/she attends if we are allowed to give them information about your child.
School Name: School Phone Number:

INSURANCE DISCLAIMER:
I hereby authorize all of my insurance benefits to be paid directly to Wilson Eye Associates, Optometrists, PA. I realize that I am responsible for all non-covered services and medical expenses incurred with this office, including your refraction. It is my responsibility to ensure that I have given Wilson Eye Associates a current copy of my insurance card and/or the name of my vision insurance. It is my responsibility to inform Wilson Eye Associates should I have a change in insurance, prior to each visit. If I do not provide Wilson Eye Associates with the correct insurance information at the time of each visit, it will be my responsibility to pay for all services received at the time of the service and to file my own insurance claims. **If for any reason your account requires legal action or referral to our collection agency, you may be charged additional fees.**

By signing this form, I state that I have read and agree to the provision stated above.

_____
Signature of Patient or Responsible Party Today's Date

_____
Print name of Parent or Responsible Party

_____
Witness of Wilson Eye Associates, Optometrists, PA

******All Co-payments and non covered services are due at the time of service.***
Please present all insurance cards to the Front Desk, after completing this form.***