SILVER CREEK DENTAL & VISION **VISION REGISTRATION**

PATIENT INFORMATION

Name (Last, First Middle) ____

Birth date (mm-dd-yyyy) ________________________ Gender (male/female) ______________

Social Security # ________________________

Home Address ____

City, State, Zip ____

Cellular phone # ________________________ Home phone # ____________________

Last eye exam date ______________________ at clinic ______________________________

Reason for eye care today ____

HEALTH HISTORY

Patient	Yes	No	Family members	Yes	No
Eye injury	___	___		___	___
Eye surgery	___	___		___	___
Eye diseases	___	___		___	___
Eye medications	___	___		___	___
High blood pressure	___	___		___	___
Diabetes	___	___		___	___
Heart problems	___	___		___	___

Other health problems ____

Medications ____

FINANCIAL AGREEMENT

Eye exam and/or treatment fee is payable at the time of service. Prescription spectacle and/or contact lenses require an advance deposit. The balance is due when the eyewear is dispensed. If you wish us to bill your vision insurance carrier, please complete the insurance information form. Our staff may assist you in estimating your insurance benefits, however they are never guaranteed. You are responsible for payment of deductibles, co-pays and non-covered services at the time of service, and insurance claims remaining un-paid after 8-weeks. Payment may be made in cash, credit, or debit. Collection action will be taken on past due accounts.

I certify that I (or dependent children) have vision coverage with an insurance company and assign directly to this clinic all insurance benefits for services rendered. I hereby authorize the clinic to release my information and signature necessary to secure the payment of benefits.

SCHEDULING AGREEMENT

I agree to reschedule my appointment 24 hours in advance or to pay $50 broken appointment fee. I understand that 2 broken or rescheduled appointments will result in termination of care at this clinic.

PRIVACY PRACTICE ACKNOWLEDGEMENT

I reviewed the Notice of Privacy Practices. And I authorize to disclose my vision information listed here ____ to the following persons/organizations and for purposes not listed in the Notice, effective immediately until further notice:

Name ____________________________________ relationship ______________________________

Name ____________________________________ relationship ______________________________

Patient or guardian signature ______________________________________ Date _________________

Guardian name & relationship ____