PATIENT REGISTRATION FORM

Thank you for choosing City Center Optometry for your eye care needs! Please help us by completing this form accurately.

____/ _____/ _____/ _____/ ____/ _____/
Title First Name Middle Name Last Name Suffix Preferred Name/ Nickname

_____/ _____/ ____/ _____/
Residence Address (Number, Street, Apartment) City State Zip Code

_____/ _____/ ____/ _____/
Mailing Address (Only if Different from Residence Address) City State Zip Code

Preferred method of communication: ☐ Phone, ☐ US Mail, ☐ Okay to text Cell, ☐ Okay to Email: _____/
The best telephone numbers to contact you during our normal business hours (9-5 M-F)?
Gender: ☐ Male, ☐ Female ☐ Cell (_____) _____/
Marital Status: ☐Single, ☐ Married, ☐ Other ☐ Work (_____) _____/
Date of Birth: ____-____-____ / ☐ Home (_____) _____/
Last 4 digits of SSN: XXX - XX - _____/ ☐ Pager (_____) _____/

Employed? ☐ Yes, ☐ No_____/ _____/
Employer's Name Occupation/Job Title

Full-time Student? ☐ Yes, ☐ No, or Part-time Student? ☐ Yes, ☐ No _____/ _____/
Name of School Grade Level
In Case of Emergency, Contact: _____ at (_____) _____/
Emergency Contact Name (First, Middle, Last, Suffix) Emergency Contact Phone Number

INSURANCE INFORMATION

_____/ _____/ _____/
VISION INSURANCE (VSP®, etc.) Full Name of Insured (First, Middle, Last, Suffix) Insured's ID Number
Insured's Relationship to Patient: ☐ Self, ☐ Spouse, ☐ Domestic Partner, ☐ Father, ☐ Mother, ☐ Guardian, ☐ Child, ☐ Other_____/

_____/ _____/ _____/
HEALTH INSURANCE (BC of CA, etc.) Full Name of Insured (First, Middle, Last, Suffix) Insured's ID Number
Insured's Relationship to Patient: ☐ Self, ☐ Spouse, ☐ Domestic Partner, ☐ Father, ☐ Mother, ☐ Guardian, ☐ Child, ☐ Other_____/

REFERRALSOURCE_____

_____/ ☐ Family Member ☐ Co-Worker
Name of Person to Thank for Referring You to Our Office (First, Middle, Last, Suffix) ☐ Friend ☐ Professional

If another person did not refer you, how were you referred to our office? ☐ VSP® Panel List/ Website, ☐ BC of CA Panel List, ☐ Mailer
☐ Convenient location, ☐ YellowPages.com, ☐ Office Website, ☐ Other

ACKNOWLEDGEMENT OF OFFICE POLICIES

I certify that my responses on this form are accurate to the best of my knowledge. <u>I certify that I understand that a cancellation fee of $48 will be charged if I fail to appear, or if I cancel or reschedule within 24 hours of any scheduled appointment.</u> I certify that I understand cancellations on eyeglasses are not permitted as all eyeglasses are custom crafted for each patient with their unique prescription. I certify that I understand that there are no refunds or exchanges and that all sales are final. I also agree to refrain from cell phone use in the office. I assume all financial responsibility for this patient's account for any amounts due, regardless of Insurance Coverage.

⇒_____/ _____/ ____-____-2021
Signature of Responsible Party Full Name of Responsible Party (First, Middle, Last, Suffix) **DATE SIGNED**

Responsible Party's Relationship to Patient: ☐ Self, ☐ Spouse, ☐ Domestic Partner, ☐ Father, ☐ Mother, ☐ Guardian, ☐ Child, ☐ Other_____/

****<u>If Responsible Party is NOT the Patient:</u>** (_____) _____/**Responsible Party's Contact Number

_____/ _____/ ___/ _____/
**Responsible Party's Address (Number, Street, Apt.) City State Zip Code