Mountain View Eye Care
Patient Registration Form

Patient Name:_____ **DOB:**_____

Mailing Address:_____**Zip:**_____

Home Phone:_____ **Other Phone:**_____

Patient's SSN#_____ **Email:**_____

Employer:_____

Responsible Party Information (Parent or Guardian Information)

Name:_____ **DOB:**_____ **SSN#**_____

Address:_____**Phone:**_____

Primary Insurance Information

Insurance Company Name:_____

Insured's Name:_____

Member ID#_____ **Group#**_____

Is the subscriber of this insurance ☐ **Yourself** ☐**Spouse** ☐**Parent**

Subscriber name (If spouse or parent) _____

Subscriber member ID#_____ **Subscriber DOB**_____

Subscriber SSN#_____ **Subscriber Group #**_____

Secondary or Supplement Insurance (If you have vision insurance, include it here)

Insurance Company Name:_____

Insured's Name:_____

Member ID# _____**Group #**_____

Is the subscriber of this insurance ☐ **Yourself** ☐**Spouse** ☐**Parent**

I authorize the release of my medical or other information necessary to process insurance claims. I also authorize payment of any medical benefits to Mountain View Eye Care for services rendered. This authorization is to remain in effect until revoked by me in writing. I further understand, I am responsible for any balances not paid by my insurance.

Patient Signature:_____ **Date:**_____