MOUNTAIN VIEW EYE CARE
PATIENT REGISTRATION FORM

PATIENT NAME:_______________________________________**DOB:**____________________

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, PLEASE 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 MountainView 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.

SIGNED____**DATE**______________