Print Form

Patient Registration

Thank you for choosing Eye Candy Optometry for your vision care. In order to provide you with the best care possible, we ask that you answer the questions below. If you prefer, we will be happy to sit down with you to help you complete this form.

Patient Information: **Today's Date:**

Patient's Name (Last, First, M.I.) _____ Date of Birth _____

Home Address _____City _____ State _____ Zip _____

Daytime Phone # _____ Home Phone # _____ Mobile phone # _____

Age _____ Male Female E-Mail Address _____

Emergency Contact Name _____ Phone # _____

Vision Insurance:

Insurance Name

_____

Employer Name _____

Subscriber's Name _____

ID# _____

Date of Birth _____ Relation _____

Medical Insurance:

Insurance Name

_____

Employer Name _____

Subscriber's Name _____

ID# _____

Date of Birth _____ Relation _____

Please let us know:

Is any family member a patient of ours? _____ If so, what is your relationship? _____

How did you find us? (Please check all that apply)

☐ Internet ☐ Insurance ☐ Referral ☐ Doctor ☐ Yellow pages ☐ Other

Whom may we thank for referring you? _____

In order to assist us in processing your insurance claim and to allow for communication with your other health care providers, please read and sign the following:

I authorize Eye Candy optometry to bill my insurance carrier on my behalf. I request that payment of authorized insurance benefits be made to this clinic for any services furnished me by R. Anthony Rabbani, O.D.. I understand that I am financially responsible for any balance not covered by my insurance carrier. I authorize any holder of medical information about me to release to my medical insurance carrier any information needed to determine the benefits payable for related services for myself and/or my dependents. **Authorization to release medical information:**

I authorize the release of medical information regarding myself/my dependents and my current condition to my referring physicians.

Notice of Privacy Practices – Acknowledgement: We keep a record of the health care services we provide to you. You may request a copy of your medical record in writing. We will not disclose your record to others unless you direct us to do so or unless legal authorities authorize or compel us to do so. You may request a copy of your medical record or get more information by contacting Eye candy optometry. Our notice of privacy practices is available at the reception desk. We will be happy to provide you with a copy per your request. I acknowledge the notice of privacy practices has been offered to me and is readily available in accordance with the Health Insurance Portability and Accountability Act.

Signature of Patient/Guardian _____