BOREING VISION CLINIC

PATIENT REGISTRATION FORM

Patient Information

Last Name	First	MI	Female ( ) Male ( )	Birth Date	Age	Home Phone#

Address	Apt#	City	State	Zip

SS#	Work#	Occupation	Marital Status

E-Mail	Cell Phone#	Primary Care Physician	Phone#

Employer Name/Address	City	State	Zip

Emergency Contact	Relationship	Phone#

INSURANCE

Vision Insurance-Name & Address

Policy#	Group#	Effective Date

Policy Holder Name	DOB	SS#

Relationship to Patient

Medical Insurance-Name & Address

Policy#	Group#	Effective Date

Policy Holder Name	DOB	SS#

Relationship to Patient

UNIFORM OF ASSIGNMENT, RELEASE OF INFORMATION AND FINANCIAL DISCLOSURE:

ASSIGNMENT OF BENEFITS:

I hereby assign or transfer payment benefits made to me and my behalf to Boreing Vision Clinic Inc. for any services furnished to me by this physician/supplier. I further agree that I am responsible for payment or charges incurred by me that are not covered by my insurance or for which my insurance has paid me.

RELEASE OF INFORMATION:

I hereby authorize Boreing Vision Clinic Inc. to release information acquired during the course of my examination or treatment to my referring physician, my primary care doctor or to an appropriate insurance carrier.

Patient Signature: Date: