PATIENT REGISTRATION FORM

PATIENT INFORMATION: (PLEASE PRINT)

Thank you for choosing Family Vision Care for your vision care needs. Please complete this form. If you have any questions or concerns, please do not hesitate to ask for assistance. We will be happy to help.

Name: ____ Date:_____________
Last First MI
Address: ____ Birthdate: _____/_____/_____

City: ______________________ State: ______ Zip Code: ________ Social Security #: _____-_____-_____

Home Phone #: (___) ____________ Work Phone #: (___) _____________ Pager / Cell #: (___) ______________

E-Mail: ________________________________Contact Preference: ☐ Home ☐ Work ☐ Pager/Cell ☐ Email

Are you: ☐ Single ☐ Married ☐ Other Are you a: ☐ Full Time Student ☐ Part Time Student ☐ Employed

Parent or Guardian Name (if minor):____

You or Your Parent's Employer: _______________________________ Your Occupation: __________________

Business Address: ___________________________ City: ______________ State :____ Zip Code: __________

If you are a student, name of school / college: ___________________ Grade / Level:_________ City: ____________

Person to contact in case of emergency: _________________________ Relationship: _______________

Phone #: ______________________

INSURANCE INFORMATION:

(Please give a picture id & all insurance cards to the assistant at the front desk)

Primary Insurance:

Insured's Name: ____ Relationship to Patient: _______________
Last First MI
Insured's Address (if different from above):____

Social Security # of Insured _____-_____-_____ Birthday of Insured: _____/_____/_____

Insurance Company: _________________________ Medical Code: ___________ Vision Code: _________________

Membership #: _________________ Group #: _________ Telephone # (if different from above): ________________

Secondary Insurance:

Insured's Name: ____ Relationship to Patient: _______________
Last First MI
Insured's Address (if different from above):____

Social Security # of Insured _____-_____-_____ Birthday of Insured: _____/_____/_____

Insurance Company: _________________________ Medical Code: ___________ Vision Code: _________________

Membership #: _________________ Group #: _________ Telephone # (if different from above): ________________

Please turn the form over and complete side two ➡

MARKETING INFORMATION

How did you hear about Family Vision Care?

- ☐ West Oahu Newpaper
- ☐ Mid Week Islander
- ☐ Paradise Pages
- ☐ Hawaiian TelCom Yellow Pages Leeward (Small) Book
- ☐ Hawaiian TelCom Yellow Pages Oahu Book
- ☐ Friend (who can we thank): ______________________________
- ☐ Oahu Book: _________________________________
- ☐ Other (please explain): _________________________________

INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Kibert Kato, O.D. or Family Vision Care, Inc. on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Center for Medicare & Medicaid Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the CMS-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

I authorize the staff of Family Vision Care, Inc. to administer such treatments as reasonable or may be necessary in connection with the condition for which I or members of my family have sought care. To the extent necessary to determine the liability for payments and to obtain reimbursement, I hereby authorize Kibert T. Kato O.D. and the staff of Family Vision Care, Inc. to apply for benefits on my behalf for covered services rendered by them. I also request that all payments from the agreed third party be made directly to Family Vision Care, Inc. or Kibert T Kato O.D.

I agree to assume responsibility of **full payment** pending my remaining balance that is not covered by the agreed third party. I certify the information I have reported on my insurance coverage is current and correct. I understand I am responsible for my own bill.

I understand payment is due at the time services are rendered unless other arrangements have been made. Furthermore, I understand that it is the policy of Family Vision Care, Inc. to release contact lens prescriptions based upon completion of the contact lens fitting. A contact lens fitting is complete when all of the necessary contact lens checks have been met and it is determined by your doctor if the contact lens is healthy.

Signature: _______________________________________ Date:_________________
(If patient under age 18, signature of parent or legal guardian required)