

Tom Determan O.D.



Stephen H. Spencer O.D.

PATIENT REGISTRATION- PLEASE PRINT CLEARLY

PATIENT NAME First Middle Last			DATE OF BIRTH		AGE
MAILING ADDRESS /PO BOX		APT. NO.	CITY	STATE	ZIP
SOCIAL SECURITY NO.		SEX <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W		SPOUSE'S NAME
HOME NUMBER	ALTERNATE NUMBER <input type="checkbox"/> CELL <input type="checkbox"/> WORK		EMAIL ADDRESS		
OCCUPATION			EMPLOYER		
PRIMARY CARE PHYSICIAN			REFERRED BY		
EMERGENCY CONTACT/ RELATION TO PATIENT			EMERGENCY CONTACT PHONE NO.		

INSURANCE INFORMATION

PRIMARY INSURANCE		SUBSCRIBER	
SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SOCIAL SECURITY NO.		RELATIONSHIP TO SUBSCRIBER
SECONDARY INSURANCE		SUBSCRIBER	
SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SOCIAL SECURITY NO.		RELATIONSHIP TO SUBSCRIBER

FOR MINORS ONLY (Under age 18)

PARENT'S NAME	PARENT'S DATE OF BIRTH
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You are ultimately responsible for payment in full of your account, not your insurance company. We can only make estimates regarding your insurance benefits based upon the information provided by you and your insurance company. In the event that your insurance company does not pay the amount expected, you will be billed for the balance. Please remember that you are responsible for any deductible.

I AUTHORIZE PAYMENT OF MEDICARE AND/ OR OTHER INSURANCE BENEFITS TO BE MADE DIRECTLY TO YUMA VISION CENTER FOR SERVICES PROVIDED TO ME. I HEREBY AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION TO MY INSURANCE COMPANIES AS IS NECESSARY TO PROCESS CLAIMS FOR SERVICES PROVIDED TO ME.

SIGNATURE OF PATIENT/ LEGAL GUARDIAN

DATE

I AM AWARE OF YUMA VISION CENTER'S NOTICE OF PRIVACY PRACTICES AND UNDERSTAND THAT A COPY MAY BE PROVIDED TO ME UPON REQUEST.

SIGNATURE OF PATIENT/ LEGAL GUARDIAN

DATE