61 Lincoln Blvd., Suite A

Lincoln, CA 95648

Phone: (916) 408-0103

Fax: (916) 408-0117

Located in the Lincoln

SAFEWAY CENTER

*A Professional Corporation*

**PATIENT REGISTRATION**

 *Please check one below (voluntary)*

 \_\_ American Indian or Alaska Native

 \_\_ Asian

 \_\_ Black or African-American

 \_\_ Hispanic

 \_\_ Latino

 \_\_ Native Hawaiian or other Pacific Islander

 \_\_ White

 \_\_ Other

***Preferred Language*:**

 English Spanish

## *Communication Preference:*

Phone E-Mail Postal

**PERSONAL INFORMATION**

SS#\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_ AGE:\_\_\_\_\_\_\_\_\_ SEX: Male Female

PATIENT NAME:\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Last First MI

MAILING ADDR:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Street City State Zip Code

HOME PH: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DAYTIME PH: (**\_\_\_\_**)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** CELL PH: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WORK PH: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMPLOYER:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**OCCUPATION:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SPOUSE INFORMATION**

NAME:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** DOB:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

SPOUSE EMPLOYER:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** WORK PH:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FAMILY DOCTOR**

FAMILY DOCTOR:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** PHONE: **(\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_** CITY / STATE / ZIP: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INSURANCE IMFORMATION**

PRIMARY INSURANCE (VISION OR MEDICAL)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

SUBCRIBER NAME**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** SUBSCRIBER DOB**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

ID# or POLICY # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** GROUP #**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

SECONDARY INSURANCE (VISION OR MEDICAL)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SUBSCRIBER NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SUBSCRIBER DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID# or POLICY # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ASSIGNMENT OF BENEFITS/INSURANCE DISCLAIMER:** I hereby irrevocably authorize my insurance company(s) or fund to make payment directly to Lincoln Optometry Center of any insurance benefits otherwise payable to me, for professional services and/or materials rendered to date, but not to exceed the stated charges for these services. I understand that I am responsible for any charges not paid by my insurance company, and for any charges not paid within sixty (60) days of billing to said insurance company. Lincoln Optometry Center is not responsible if your insurance company does not pay for your professional services and materials. You are financially responsible for non-covered services and/or materials. By signing this form, I give Lincoln Optometry Center the right to bill my insurance company, and to use this form as my "signature on file". A copy of this authorization shall be valid as the original.

**SERVICES MAY BE PAID WITH CASH, CHECK (UPON APPROVAL), VISA, MASTERCARD, DISCOVER CARD OR ATM.**  In services requiring lab work (glasses and contact lenses), a minimum of 50% deposit is required and the remaining 50% is due upon the delivery of materials. There is a minimum of $25 returned check fee.

**RELEASE OF INFORMATION:** I hereby authorize Lincoln Optometry Center to furnish and disclose all known facts concerning my care to my insurance company(s) or fund, and to other Optometrist or Physician as deemed necessary to provide for my care. A copy of this authorization shall be valid as the original.

I GIVE MICHAEL J. PROIETTE, OD, INC., dba LINCOLN OPTOMETRY CENTER, PERMISSION TO TREAT ANY DISEASE OF THE EYE THEY ARE LICENSED TO TREAT, INCLUDING GLAUCOMA.

**X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **SIGNATURE: PATIENT / LEGAL GUARDIAN** (if under 18) **DATE**

Patient Registration Form (Rev. 4-1-16)