KENNEWICK VISION CARE REGISTRATION FORM

Full Name: _____

Nickname_____ SSN_____

Date of Birth_____ Age _____ Gender: M F

Street_____

City_____ State_____ Zip_____

Home #_____ Work #_____

Cell #_____ E-mail _____

Preferred Contact: Cell # Work # Home # E-mail

Marital Status: Married Single Widowed Divorced

Emergency Contact: _____

Phone_____ Relationship_____

Employer or school: _____

Occupation: _____

Preferred Language: _____

Race: American Indian/Alaskan Native Asian Caucasian
African American Native Hawaiian/Other Pacific Islander

Other: _____

Ethnicity: Hispanic/Latino Non-Hispanic/Latino

How did you find us?

Who may we thank for referring you to our office?

_____

If not referred, how did you choose our office?

Sign/Building Yellow Pages Newspaper/Radio/TV

Web Page Insurance list Other_____

Primary Insurance_____

Subscriber's Name_____

Subscriber's Insurance ID #_____

Subscriber's Group #_____

Secondary Insurance_____

Subscriber's Name_____

Subscriber's Insurance ID #_____

Subscriber's Group #_____

Parent/Guardian Information

Name_____ Relation_____

Date of Birth_____ SSN_____

Address (If Different) _____

Phone_____

We cannot accept divorce decrees as assignments of responsibility for a child's bills. The accompanying parent/ guardian is financially responsible for the services rendered.

In order to control the cost of billing, we ask that the patient's portion be paid at the time services are rendered unless other arrangements are made in advance. All professional services and materials are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts over 90 are subject to collection fees. There will be a service charge of $35.00 on all returned checks.

Initial _____

I understand that the information I have given is correct to the best of my knowledge. I authorize Kennewick Vision Care to release to my insurance company any information required to process my claims.

_____ _____

Signature of Patient/ Signature of parent or Guardian Date