ZAKER OPTOMETRY

NEWPORT BEACH

Patient Registration Information

PATIENT INFORMATION

First Name:_____ MI:_____ Last Name:_____

Address:_____ Date of Birth:_____

City, State, Zip:_____ Social Security #:_____

Phone # (circle): Hm / Wk / Cell _____ Driver's License #:_____

Phone # (circle): Hm / Wk / Cell _____ Employer:_____

Marital Status (circle): Single / Married / Divorced / Widowed Occupation:_____

Gender (circle): Male / Female How did you hear about our office?_____

Email Address (print clearly):_____

EMERGENCY CONTACT INFORMATION

Name:_____ Relationship to patient:_____

Phone # (circle): Hm / Wk / Cell _____

VISION INSURANCE / RESPONSIBLE PARTY INFORMATION (if different from the patient)

Name of Insurance:_____ Employer:_____

Subscriber Name:_____ Subscriber D.O.B.:_____

Member ID #:_____ Group #:_____

Relationship to Subscriber:_____ Social Security #:_____

Phone # (circle): Hm / Wk / Cell_____

PRIMARY MEDICAL INSURANCE / RESPONSIBLE PARTY INFORMATION (if different from the patient)

Name of Insurance:_____ Employer:_____

Subscriber Name:_____ Subscriber D.O.B.:_____

Member ID #:_____ Group #:_____

Relationship to Subscriber:_____ Social Security #:_____

Phone # (circle): Hm / Wk / Cell_____ Plan (circle): PPO / EPO / POS / HMO

SECONDARY MEDICAL INSURANCE / RESPONSIBLE PARTY INFORMATION (if different from the patient)

Name of Insurance:_____ Employer:_____

Subscriber Name:_____ Subscriber D.O.B.:_____

Member ID #:_____ Group #:_____

Relationship to Subscriber:_____ Social Security #:_____

Phone # (circle): Hm / Wk / Cell_____ Plan (circle): PPO / EPO / POS / HMO

***** Please provide your medical insurance card and driver's license to the receptionist *****

Please turn over

INSURANCE AUTHORIZATION

By signing this document, I acknowledge that I understand the following:

1. I authorize payment of insurance benefits for services and/or materials to Zaker Optometry Newport Beach.
2. I authorize the release of any medical information necessary to process insurance claims on my behalf.
3. The amounts quoted by my insurance company are not a guarantee of payment of the insurance claims.
4. I am financially responsible for services and/or materials that are not paid by my insurance company.

NOTICE TO OUR PATIENTS REGARDING OFFICE POLICIES

There are no refunds for services and/or materials ordered from Zaker Optometry Newport Beach. We will gladly exchange materials within 30 days of purchase. All checks returned by the bank are subject to $35 non-sufficient funds charge.

Patient Signature:_____ Date:_____

Print Name (if parent or guardian):_____ Relationship to Patient:_____

NOTICE OF PRIVACY PRACTICES

In the course of providing service to you, we create, receive and store protected health care information that identifies you. It is often necessary to use and disclose this health care information for the purposes of treatment, payment, and health care operations involving our office. The Notice of Privacy Practices, which you have been given, describes these uses and disclosures in detail.

I acknowledge that I have received a copy of the Notice of Privacy Practices from Zaker Optometry Newport Beach.

TO WHOM IT MAY CONCERN:

I AUTHORIZE Zaker Optometry Newport Beach to release information regarding my medical care or financial/insurance information to:

_____ until revoked in writing by me, the undersigned.

(Spouse, legal guardian, family member)

Patient Signature:_____ Date:_____

Print Name (if parent or guardian):_____ Relationship to Patient:_____