VISION ONE INC.

REGISTRATION FORM

(Please Print)

Today's date:	E-mail Address:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security #: (last 4 digits)	Phone: ( )

P.O. Box:	City:	State:	ZIP Code:

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Policyholder's full name:	Birth date: / /	Address (if different):	Phone: ( )

Please indicate **primary** insurance: ID number:

Policyholder's SS # (last 4 digits)	Birth date: / /	Group #:	Policy #:	Relationship to policyholder:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group #:	Policy#:

FINANCIAL POLICY

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Vision One, Inc. or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____, have reviewed a copy of Vision One, Inc.'s Notice of Privacy Practices.

Patient/Guardian signature *Date*

EMERGENCY CONTACT

Name/ Relationship *Phone number*