REGISTRATION FORM

Please print

PATIENT INFORMATION:

Patient name: _____ Date: _____

Address: _____ Apt. number: _____

City: _____ State: _____ Zip: _____

Home phone: (_____) _____-_____ Work phone: (_____) _____-_____ ext: _____

Cell phone: (_____) _____ - _____

Date of birth: _____ / _____ / _____ Social Security Number: _____ / _____ / _____

Marital status: Married / Single / Widowed / Divorced Sex: M / F Email Address: _____

Pediatric Patients: Mother's name: _____ Father's name: _____

INSURANCE INFORMATION:

Primary Insurance Plan _____ ID# _____

Insured name: _____

Insured Address: _____ City: _____ State: _____ Zip: _____

Relationship to patient: ____ Self, _____ Spouse, _____ Parent or legal guardian.

Secondary Insurance Plan: _____ ID# _____

Insured name: _____

Insured Address: _____ City: _____ State: _____ Zip: _____

Relationship to patient: ____ Self, _____ Spouse, _____ Parent or legal guardian.

I authorize any holder of medical information about me to release to my insurance company or their agents any information needed to determine these benefits payable for related services. Once Dr. DeLugan / Dr. Thurm has obtained this one time authorization he may submit future claims on either an assigned or non-assigned basis without any additional release.

I understand that I am responsible for any payments for services I receive not covered by or paid for by my insurance company.

I understand that most insurance plans do not cover contact lenses or contact lens services and that there will be an additional charge for those services.

Signature: _____ Date: _____