

## PATIENT REGISTRATION

**PLEASE PRINT** and be sure to complete the entire form and bring with you to your eye exam.

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Last Name	First Name	Middle Name
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Social Security Number	Date of Birth	Age	Sex
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Home Address	Street	City	State	Zip Code
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Home Telephone	Cell Telephone	Business Telephone
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Employer	Occupation
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**RESPONSIBLE PARTY** – Please indicate the person listed as the policyholder and / or who will be responsible for the bill (spouse, parent, etc.).

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Name of Insured / Responsible Party	Address (if different from above)	City	State	Zip
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Home Telephone	Cell Telephone	Business Telephone
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Relationship to patient	Date of Birth	Social Security Number
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### **VISION INSURANCE INFORMATION**

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Name of Insurance Carrier:	Vision Service Plan (VSP) / Town of Flower Mound (circle one)
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Insured Employee / Member Name	Member ID / Social Security No.
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Name of Group Insured (Employer)	Employer Telephone
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I hereby authorize payment directly to Ousley Vision Center by my insurance company, for any services or materials incurred on behalf of my family or myself. I also authorize release of any information regarding the history, treatment or benefits payable concerning claims made to my insurance company. I understand that any and all charges not covered by my insurance company are my personal responsibility, included by not limited to co-payments and deductibles. Copies of these signatures shall be as valid as the originals.

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Print Patient Name	Patient Signature	Date
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Print Insured's Name	Insured's / Responsible Party Signature	Date
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