



Curtis W. Meredith, O.D.

PATIENT REGISTRATION

Please check one below (voluntary)

- American Indian or Alaska Native
- Asian
- Black or African-American
- Hispanic
- Latino
- Native Hawaiian or other Pacific Islander
- White
- Other

Preferred Language:

English Spanish

Communication Preference:

Phone E-Mail Postal

PERSONAL INFORMATION

SS# _____ - _____ - _____ DOB: ____/____/____ AGE: _____ SEX: Male Female

PATIENT NAME: _____
Last First MI

MAILING ADDR: _____
Street City State Zip Code

HOME PH: (____) _____ DAYTIME PH: (____) _____ CELL PH: (____) _____

E-MAIL ADDRESS: _____

WORK PH: (____) _____ EMPLOYER: _____ OCCUPATION: _____

SPOUSE INFORMATION

NAME: _____ DOB: _____

SPOUSE EMPLOYER: _____ WORK PH: _____

FAMILY DOCTOR

FAMILY DOCTOR: _____ PHONE: (____) _____ CITY / STATE / ZIP: _____

INSURANCE INFORMATION

PRIMARY INSURANCE (VISION OR MEDICAL) _____

SUBSCRIBER NAME _____ SUBSCRIBER DOB _____

ID# or POLICY # _____ GROUP # _____

SECONDARY INSURANCE (VISION OR MEDICAL) _____

SUBSCRIBER NAME _____ SUBSCRIBER DOB _____

ID# or POLICY # _____ GROUP # _____

ASSIGNMENT OF BENEFITS/INSURANCE DISCLAIMER: I HEREBY IRREVOCABLY AUTHORIZE MY INSURANCE COMPANY(S) OR FUND TO MAKE PAYMENT DIRECTLY TO LINCOLN OPTOMETRY CENTER OF ANY INSURANCE BENEFITS OTHERWISE PAYABLE TO ME, FOR PROFESSIONAL SERVICES AND/OR MATERIALS RENDERED TO DATE BUT NOT TO EXCEED THE STATED CHARGES FOR THESE SERVICES. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHARGES NOT PAID BY MY INSURANCE COMPANY, AND FOR ANY CHARGES NOT PAID WITHIN SIXTY (60) DAYS OF BILLING TO SAID INSURANCE COMPANY. BY SIGNING THIS FORM, I GIVE LINCOLN OPTOMETRY CENTER THE RIGHT TO BILL MY INSURANCE COMPANY, AND TO USE THIS FORM AS MY "SIGNATURE ON FILE". A COPY OF THIS AUTHORIZATION SHALL BE VALID AS THE ORIGINAL.

SERVICES MAY BE PAID WITH CASH, CHECK (UPON APPROVAL), VISA, MASTERCARD, DISCOVER CARD OR ATM. IN SERVICES REQUIRING LAB WORK (GLASSES AND CONTACT LENSES), A MINIMUM OF 50% DEPOSIT IS REQUIRED AND THE REMAINING 50% IS DUE UPON THE DELIVERY OF MATERIALS. THERE IS A MINIMUM OF \$25 RETURNED CHECK FEE.

RELEASE OF INFORMATION: I HEREBY AUTHORIZE LINCOLN OPTOMETRY CENTER TO FURNISH AND DISCLOSE ALL KNOWN FACTS CONCERNING MY CARE TO MY INSURANCE COMPANY(S) OR FUND AND TO OTHER OPTOMETRISTS OR PHYSICIANS UPON MY REQUEST. A COPY OF THIS AUTHORIZATION SHALL BE VALID AS THE ORIGINAL.

I GIVE CURTIS W. MEREDITH, OD, INC., dba LINCOLN OPTOMETRY CENTER, PERMISSION TO TREAT ANY DISEASE OF THE EYE THEY ARE LICENSED TO TREAT, INCLUDING GLAUCOMA.

X _____
SIGNATURE: PATIENT / LEGAL GUARDIAN (if under 18)

X _____
DATE