

## Patient Registration Form

### Patient Information

**Full Name:** \_\_\_\_\_ **Mr. / Mrs. / Ms. / Miss Preferred Name:** \_\_\_\_\_  
(Last) (First) (M.I.)

**Mailing Address:** \_\_\_\_\_ **City, State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Day Phone:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **Home Phone:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Social Security #:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

How did you hear about us?

Newspaper                       TV Commercial  
 Hauser-Ross Patient     KHS Employee  
 Other: \_\_\_\_\_

**Email Address:** \_\_\_\_\_ **Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Who is your medical doctor?** \_\_\_\_\_ **City:** \_\_\_\_\_

**Emergency Contact (not living with you):**

**Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

### Responsible Billing Party

**Name:** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_ **City, State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**Additional Family Members Covered:** \_\_\_\_\_

### Insurance Information

**Do You Have Medicare?**      Yes                      No

**Medicare Insured Name:** \_\_\_\_\_

**Medicare #:** \_\_\_\_\_

**Secondary Ins. / Medical Ins.:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Insured Name:** \_\_\_\_\_ **Insured's ID:** \_\_\_\_\_

**Insurance Address:** \_\_\_\_\_

I give my permission for Hauser-Ross Optical to bill Medicare directly for any services rendered.  
  
*Pt. Signature:* \_\_\_\_\_

**Other than those listed above, is there anyone else who is authorized to receive information:**

\_\_\_\_\_

\_\_\_\_\_

Most insurance policies pay only a portion of your total charges. If you have questions about your coverage, please contact your representative! We **DO NOT** guarantee the accuracy of the benefit information given to us by insurance companies. Please understand that financial responsibility for your account is yours, not your insurance company's. Delinquent accounts may be subject to collection fees.

**SIGNED:** \_\_\_\_\_ **DATE:** \_\_\_\_\_