PATIENT REGISTRATION FORM

Drs. Orr and Routledge, Optometrists

NAME ____ DATE OF BIRTH_____________

ADDRESS____

CITY___________________________STATE_____________ZIP CODE_________________

PHONE: (HOME)___________________(WORK)____________

EMAIL: ____

OCCUPATION______________________

EMPLOYER________________________ADDRESS_____________________________________

SPOUSE OR PARENT____

EMPLOYER________________________WORK PHONE_________________________________

REFERRED BY____

PLEASE LIST OTHER FAMILY MEMBERS THAT HAVE BEEN HERE

NAME	RELATIONSHIP	DATE OF BIRTH
1.		
2.		
3.		
4.		

To hold down fees, we appreciate payment for your exam on the day of your exam. For contact lenses or glasses, we require half down payment to order and the balance on pickup.

INSURANCE:
Please have your insurance card available for the receptionist and sign the appropriate box below to assign payment to the doctor.

MEDICARE:
I request that payment of authorized Medicare benefits be made on my behalf to Drs. Orr and Routledge for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits or the benefits payable for related services.

Signed ____Date_________________________

OTHER INSURANCE:
I request that payment of authorized insurance benefits be made on my behalf to Drs. Orr and Routledge for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to my insurance company/companies any information needed to determine these benefits.

Signed ____Date_________________________