PRO OPTICAL PATIENT REGISTRATION FORM

JEFFREY KUBLIN, O.D. CHERYL DEPAOLO JOST, O.D. BAO-KIM NGUYEN, O.D. DUANE SMITH, O.D

Legal Name _____ _____ _____
Mr. Mrs. Ms. Dr. Fr. (circle one) First MI Last

Address _____ **City** _____ **State** _____ **Zip** _____

Gender: ☐ Male ☐ Female **Birth Date**: ____/____/_____ **Age:** **Last 4 of Social Security #:** _____
Month Day Year

Home Phone (____)_____ **Work Phone (____)**_____ **Cell Phone (____)**_____ ☐ **Text Ok**

Email address _____

Preferred Method of Contact: ☐ Cell phone ☐ Home phone ☐ Email ☐ Text

Employer_____ **Type of work you do** _____

Closest

Relative_____**Relationship**_____**Phone**(___)_____

Health Insurance_____ **Policy Number**

_____

Vision Coverage (if applicable) ☐ VSP ☐ EyeMed ☐ Davis Vision **Policy Number**_____
Member ID Number

How did you hear about our office? _____

Primary Reason for Visit_____ **Last Eye Exam** _____

What hobbies or sports do you participate in? _____

Do you currently wear eyeglasses? (circle one)	Yes	No	Distance	Reading		Bifocal
Do you currently wear contact lenses? (circle one)	Yes	No	Gas Perm. Daily Wear	Hard Extended Wear	Soft	Disposable

Any Allergies? _____

Current Eye Medication(s): _____

Family History of Eye Disease: _____

General Medical History: _____

Current General Medication(s): _____

CONTACT LENS FEES Most insurance carriers will not cover procedures related to contact lenses unless they are medically necessary. Most contact lenses are for cosmetic purposes. Please ask us for a quote of these additional fees.

ASSIGNMENT OF BENEFITS I request that payment of authorized Medicare or other assigned insurance be made directly to Pro Optical / Jeffrey Kublin, O.D / Cheryl DePaolo Jost, O.D./ Bao-Kim Nguyen, O.D./ Duane Smith, O.D. any services rendered. I authorize this holder of medical information about me to release to CMS and agents and information to determine these benefits payable for related services.
Referral: If a referral is required through your insurance, it is the patient's responsibility to obtain the referral.

I understand that I am responsible for any non-covered services.

Signature of Patient X _____ Date_____
(Parent / guardian, if under 18)

If patient is under 18 years of age, guarantor (person responsible for payment) is:_____

H.I.P.A.A / NOTICE OF PRIVACY PRACTICES
I acknowledge that I have been provided a copy of the Notice of Privacy Practices.

Signature of Patient X_____

Date_____

(Parent / guardian, if under 18)