PROVISION LASER EYE CENTER REGISTRATION

Date:_____

Name:_____
Last **First** **Middle**

Address:_____

City:_____**State:**_____**Zip:**_____

Phone(H):_____**(W)**_____**(Cell)**_____

Northern Address:_____

City:_____**State:**_____**Zip:**_____

Email Address: _____

Sex **M** **F** **Single** **Married** **Widowed**

Social Security #:_____**Date of Birth:**_____

Spouse:_____

Social Security #_____**Date of Birth:**_____

If minor, who is responsible for bill?_____

Address:_____**City:**_____**Zip:**_____

Social Security #:_____**Date of Birth:**_____

Whom may we thank for referring you:_____

Primary Insurance:_____

Secondary Insurance:_____

Contact in case of emergency:_____**Phone:**_____

I consent to treatment, diagnostic, and/or therapeutic services ordered by Provision Laser Eye Center. I authorize payment by my insurance company/companies on my behalf for services provided. I certify the information given by me under Title XVIII of the Social Security Act is accurate. I understand I am responsible for any unpaid balance including deductibles, co-pays, and any non-covered services.

_____ _____
Patient Signature or Responsible Party **Date**