Yaldo Eye Center
the VISION experts

Patient Registration Form

Patient Name		Home Phone*		Alternate Phone*
E-mail		Occupation or Previous Occupation		
Address		City	State	Zip Code
Gender ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married	Social Security Number		Date of Birth

Insurance Information

Primary Insurance

Subscriber Name: _____ Subscriber DOB _____

Policy Number: _____ Group Number: _____

Employer: _____

Secondary Insurance

Subscriber Name: _____ Subscriber DOB _____

Policy Number: _____ Group Number: _____

Employer: _____

Emergency Contact Information:

Name: _____ Phone: _____

If an Optometrist, Optical Company, Medical Doctor, friend or relative referred you, please provide their name: _____

If you were not referred to us, how did you hear about Yaldo Eye Center? (Please check one.)
☐ Television ☐ Radio ☐ Yellow Pages ☐ Internet ☐ Newspaper

Authorization: I hereby authorize the release of any medical information necessary to process my insurance. I also hereby authorize payment directly to the provider of services. I understand that I am financially responsible for charges not covered by this authorization.
Acknowledgement: I acknowledge that interest may be charged on all accounts that are 90 days or more post due at a rate of 1½% per month, annual rate 18%. I understand that interest charges will be added to any account I have that is 90 days or more past due and hereby agree to pay such charges if levied.
* I agree that Yaldo Eye Center is authorized to reach me at any phone number provided and may leave a message if I am not available. I may also be contacted by e-mail.

Patient signature: _____ Date: _____

- YALDO EYE CENTER COMMENTS -