SHARPER VISION

913.787.6724
www.sharpervisionks.com

Registration
Sharper Vision, PA

Date	Account ID	Chart ID	Other ID	Internal Use

Patient Information

Name Last: First : MI: Gender: M F

Marital Status: DOB: / / Age: E-mail:

Address: City: State: Zip Code:

Phone: Home Cell: Work:

Emergency Contact: Phone: Relationship:

Employer Name: Employer Address: Occupation:

Patient Social Security Number: Spouse (or Parent's) Name:

Purpose of this visit or vision problems, i.e. vision change, contact lenses/new glasses:

Physician: Family Physician: Referring Physician:

Preferred Pharmacy Name: Address: Phone:

Communication Preference: ☐ Phone ☐ E-mail: ☐ Texting May we use the email provided for this communication? ☐ Y ☐ N

Medical Insurance

1).Primary Medical Insurance Name:

Policy Holder Name: Policy Holder's DOB: / /

Relationship: Member ID: Group ID:

2).Vision Insurance Name:

Policy Holder Name: Policy Holder's DOB: / /

Relationship: Member ID: Group ID:

Guarantor (Person to be billed, if different than patient)

1). Name Last: First: MI: Gender: M F Marital Status: DOB: / / Age:

Address: City: State: Zip Code:

Phone Home: Cell: Work: E-mail:

Employer Name: Employer Address: Occupation:

Very Important! New Patients Only:

How did you hear of us: Who may we thank for referring you to our office:

If not referred, how did you choose our office: Another Dr. ☐ Insurance List ☐ Social Media ☐ In the Area/Location ☐

Patient's or Authorized Person's Signature:

I the undersigned give my authorization to treat and assign directly to Sharper Vision, PA, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my Insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices, I authorize the Practice to use and disclose my health information for purposes to treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature: Date: