Today's date:_______________

MATT WEAVER, O.D.

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's Last name: First: Middle:				Marital status (circle one) Single / Mar / Div / Sep / Wid
Birth date: / /	Age:	Sex: ❑ M ❑ F	Email address:	
Address:			Home phone no.: ( )	Cell phone no.: ( )
City:			State:	ZIP Code:
Patient's Occupation & Place of Employment:			Hobbies:	

Chose /Referred to office by (please check one box): ❑ Dr. _______________ ❑ Insurance Plan

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

VISION INSURANCE INFORMATION

Name of Insurance Plan:		
Name of policy holder:		Policy holder's S.S. no.:
Birth date: / /	Group no.:	Policy no.:

Patient's relationship to policy holder: ❑ Self ❑ Spouse ❑ Child ❑ Other

- The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Matt Weaver, O.D. I understand that I am financially responsible for any balance. I also authorized the release of my medical records to any insurance company with whom I have coverage or for any referrals arranged by this office. In addition, I authorize treatment deemed necessary by Matt Weaver, O.D.

- I acknowledge that I received or have been offered a copy of the Notice of Privacy Practices.

_______________________________________ _______________________

Patient/Guardian signature *Date*