Welcome Back To The Office
PROFESSIONAL EYECARE ASSOCIATES, INC
Todd Niemeier OD Andrew Moore OD Morgan Hussmann OD

PATIENT REGISTRATION FORM

Please Indicate Any Changes Since Your Last Visit.

PATIENT NAME_____
(LAST) (FIRST) (MI) (SOC SEC #)

STREET OR BOX NO_____CITY_____ST_____ZIP_____

HOME PHONE_____CELL PHONE_____WORK PHONE_____

PATIENT EMPLOYER_____OCCUPATION_____

EMPLOYER ADDRESS_____PHONE_____

___F ___M BIRTH DATE_____

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RESPONSIBLE PARTY INFORMATION

___SPOUSE ___PARENT ___GUARDIAN

NAME_____BIRTH DATE_____SOC SEC #_____

ADDRESS_____CITY_____ST_____ZIP_____

HOME PHONE_____CELL PHONE_____WORK PHONE_____

EMPLOYER_____ EMPLOYER ADDRESS_____

RELATIVE_____PHONE_____ADDRESS_____

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PRIMARY INSURANCE	SECONDARY INSURANCE
NAME OF INS_____	NAME OF INS_____
POLICY HOLDER NAME_____	POLICY HOLDER NAME_____
BIRTH DATE_____SOC SEC_____	BIRTH DATE_____SOC SEC_____
POLICYID/GROUP#_____	POLICYID/GROUP#_____
EFFECTIVE DATE_____	EFFECTIVE DATE_____

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PLEASE READ CAREFULLY & SIGN: I, the undersigned, assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance. I understand that if any unpaid balance is assigned to a collection agency or attorney, I will be responsible for paying a collection fee of 33.3% that will be added to my account. I hereby authorize the doctor to release all information to secure the payment of benefits. I authorize the use of this on all insurance submissions. I have also been notified of the Notice of Privacy Practices from Professional Eyecare Associates.

*_____ *_____
Responsible Party Date

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Do you own more than one pair of glasses?	Y	N	Do you work on a computer?	Y	N
Would you benefit from thinner, lighter lenses?	Y	N	Do you spend a lot of time outdoors?	Y	N
Are you bothered by restrictive windows, lines, or head tilting?	Y	N	Do you have problems with glare?	Y	N
Are there times when you would rather not wear glasses?	Y	N	Do you have sensitivity to light?	Y	N
Are there any changes in your health history information?	**Y**	**N**			

Please List Any Changes: