Registration Form

Patient Information	SS #	Date:
Last Name:	First:	Middle:
Mailing Address:		
City:	State:	Zip Code:
Physical Address:		
City:	State:	Zip Code:
Home Phone: ( )	Second Phone: ( )	
Date of Birth:	Sex: □ Male □ Female	

Marital Status: □ Married □ Single □ Widowed □ Separated/Divorced
Occupation: □ Employed □ Homemaker □ Child/Student □ Retired □ Disabled □ Other

Employer:			
Company Name:			
Address:			
City:	State:	Zip Code:	Telephone: ( )

How did you find out about Carolina Vision Center? □ Friend/Relative □ Phone Book
□ Radio □ Newspaper □ Online □ Doctor □ Other ___________________

Referring Doctor:	
Family EYE Doctor:	Family MEDICAL Doctor:
Insurance Information (Need Copy of Card)	
Insurance Company:	Policy Holder Name:
Policy #:	Group #:
Social Security #:	Date of Birth:
Secondary Insurance Information (Need Copy of Card)	
Insurance Company:	
Policy #:	Policy Holder Name:
Social Security #:	Group #:
	Date of Birth:

I give my permission for Carolina Vision Center or any of their physicians to: 1) Release to the Social Security Administration, any insurance carriers or any organization that is a third party payor responsible for payment of my obligation information concerning my insurance claim, 2) file my insurance claim with Medicare or an insurance company and assign the claim benefit paid to Carolina Vision Center, 3) Should my doctor(s) deem it necessary, in their sole discretion, to forward my medical records or portions thereof to another medical provider for furtherance of my medical care, 4) to initiate a complaint to the Insurance Commission for any reason on my behalf pertaining to my account, 5) to use an automated appointment reminder system to call my cell phone and 6) in consideration of my medical care by Carolina Vision Center, I, my heirs and assigns agree to arbitrate any issues or claims raised by either myself, my heirs or assigns against Carolina Vision Center, their agents or employees concerning any issue regarding my medical care, with exception of any billing issues.

I certify that; A) the information I have given is correct and B) I have complete authority to execute document on behalf of myself or patient and C) I understand that I am responsible for any unpaid balance not paid by my insurance company.

Patient or Guarantor Signature: ___________________________ Date: _________________________