KEVIN L. HENNE O.D.
ALLISON M. SCHNEIDER, O.D.

PATIENT REGISTRATION

Patient Information:

Last Name: _____First Name: _____Middle: _____ Todays Date: ____/____/____

Date of Birth: _____/_____/_____Last four digits of SSN: _____ Age: _____Sex: _____ Marital Status: _____

Mailing Address: _____ Apt. #: ____City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____Email: _____

Emergency Contact:_____Relation to Patient:_____Phone Number: _____

Is it okay to speak with this person regarding your medical information? Yes____ No____

Employer Information:

Patient Employer: _____ Employer Phone: _____

Employer Address: _____ Occupation: _____

Contact Lens Fees:

New Family Eye Care Patient or New Contact Lens Wearer - Fitting:

Sphere: $75 Toric/Astigmatism: $95 Multifocal/Monovision: $125

Established Family Eye Care Contact Lens Patient - Evaluation:

Sphere: $45 Toric/Astigmatism $55 Multifocal/Monovision: $65

Please initial if you wear or are interested in wearing Contact Lenses _____

Guarantor/Responsible Party (If patient is minor):

Last Name: _____ First Name: _____ Relationship to patient: _____

Date of Birth: _____/_____/_____ Last 4 of Social-_____

Employer: _____ Employer Phone: _____

I hereby authorize any holder of medical or other information about me to release to the SSA and HCFA or its intermediaries or carriers if any information for this or related Medicare and Medicaid claims. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to Kevin L Henne, OD. I also acknowledge I have read a copy of the Notice of Privacy Practices provided by this office.

Signed: _____ **Date:** _____

I acknowledge that all co-pays, deductibles, and co-insurances are due at time of service. A minimum of 50% deposit is due for all materials upon ordering. Balance of materials is due in full at time materials are picked up.
I acknowledge that my insurance will be billed as a courtesy to me, and if my insurance denies any charges and or services, I am fully responsible for those charges. Any unpaid balances greater than 120 days will be placed in collections.

Signed: _____ **Date**: _____

THANK YOU FOR CHOOSING FAMILY EYE CARE!