PATIENT Registration Form

Lisa M Testa OD Inc

Welcome to our office! Thank you for choosing our office for your eye care services. Please take the time to complete this questionnaire accurately and completely. It helps us do the best job possible for you. This information is held in complete confidence as it is part of your permanent record, and will not be released to anyone unless you authorize its release in writing.

Preferred Salutation: Dr. Mr. Mrs. Ms. Miss. Other _____

First Name | Middle Name | Last Name | Maiden Name

Home Address | City | State | Zip Code

Office Address | City | State | Zip Code

Home Telephone | Office Telephone / Ext | Employer | Occupation

Responsible Party (If different than above) | Address

Referred By | Birth date | Date Last Exam | Previous Eye Doctor

Insurance Information

We require all insurance information prior to services being provided. Due to the diverse nature of many eye conditions, disorders, and procedures, many of the services we provide are covered by your MAJOR MEDICAL INSURANCE rather than routine vision coverage. Please provide us with the following information even if you believe that you are seeing us for a non-medical reason. We also require your PRIMARY CARE PHYSICIAN'S NAME & TELEPHONE NUMBER.

Medical Insurance Company | Policy Holder SS# | Primary Care Physician / Tel #

Vision Insurance Company | Policy Holder SS# | Policy # / Group #

Financial Policy

Please indicate method of payment: [ ] Cash / Check [ ] Visa / Mastercard / Other: _____

All CO-Payments and Individual portions of your balance are due at the time of service. If you participate in any of the following insurance plans, you are responsible for these amounts at the time of service. We will bill your inwurance directly for their portion. If you believe that your insurance company provides coverage for your services, but we are not on your provider list, payment in full for all services and materials is due at time of service. Please submit the provided receipt with your claim form directly to your insurance company. This will expedite the reimbursement of funds directly to you.

[___] Vantage [___] PACC [___] HMO [___] Blue Cross [___] Good Health [___] VSP [___] OHP [___] Aetna
[___] Pacific Source [___] BUBB [___] Medicaid [___] Medicare

I authorize the release of any medical or other information necessary to process any claims arising from services and materials provided. I also request payment of government or private insurance benefits to the physician accepting assignement for the services and materials provided. I also understand that I assume all financial responsability for this account for any and all amounts due regardless of insurance coverage.

Signature | Date | Relationship to Patient