



REGISTRATION SHEET

PATIENT NAME _____

PARENT OR GUARDIAN NAME IF UNDER 18 _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____

CELL PHONE _____ EMAIL ADDRESS _____

YOUR CONTACT PREFERENCE HOME WORK CELL MAIL

ALTERNATIVE PONE # AND CONTACT PERSON _____

INSURANCE NAME _____ POLICY # _____

Check here to give Vision Care of Maine staff permission to speak with your contact person regarding health issues.

DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____

SEX: M or F SINGLE _____ MARRIED _____ DIVORCED _____ OTHER _____

PATIENT EMPLOYER _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

FAMILY PHYSICIAN _____

REFERRED BY DR _____

RELEASE OF INFORMATION

I hereby authorize release of information to Medicare and request that payment of Medicare benefits be made on my behalf to Vision Care of Maine, for any covered services furnished to me by the providers at Vision Care of Maine.

For all other insurances, I authorize Vision Care of Maine, to release medical information needed by my insurance company for the purpose of providing medical and surgical eye care service.

I hereby acknowledge the receipt of Notice of Privacy Policy given to me.