Swartz Family Eyecare, LLC
Patient Registration Form
(Please Print)

A. PATIENT INFORMATION			
Patient's First Name:	**Middle Initial:**		**Last Name:**
Patient's Date of Birth:	**Patient's SSN:**		**Email Address:**
Address:	**City:**	**State:**	**Zip Code:**
Phone:	**(circle one) Cell or Home**		
Other immediate family members seen here:			

B. BILLING/INSURANCE INFORMATION			
Person responsible for bill:	**Date of Birth:**	**Address (if different): Home phone (if different):**	
Is this person a patient here? Yes No		**Responsible Party's SSN:**	
Name of Insurance holder:	**Date of Birth:**	**Insured's SSN:**	
Name of Vision Care Plan:		**Name of Medical Insurance:**	

C. ACKNOWLEDGEMENT OF RESPONSIBILITY

The information provided on my medical insurance card and/or vision care plan card provided above are true to the best of my knowledge. When making a third party claim, I authorize Swartz Family Eyecare, LLC to bill the medical insurance company and/or vision care plan on my behalf for any covered charges. I authorize the release of any medical information necessary for processing the claim. I also authorize my medical insurance company and/or vision care plan to pay insurance benefits on my behalf to Swartz Family Eyecare, LLC directly. I understand and agree that regardless of my medical insurance and/or vision care plan benefits, I (or my guarantor) am responsible to pay the balance on my account for all professional services and materials provided.

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Patient/Guardian Signature **Date**