

Vision North Patient Registration Form Dr. Paul M. Cangiano

Legal Name _____

Mr. Mrs. Ms. Dr. Fr.

Address _____ City _____ State _____ Zip _____

Gender: Male Female Home Phone (____) _____ Work (____) _____

Birth Date ____/____/____ Age: Social Security # _____ Last eye Exam _____

Employer _____ Type of work you do _____

Personal email address _____

Health Insurance _____ Policy Number _____

Vision Coverage (if applicable) () VSP () Davis Vision Policy Number _____

Primary Care Physician Information:

Name _____ Phone _____

How did you hear about our office? _____

Primary Reason for Visit: _____

What hobbies or sports do you participate in? _____

Do you currently wear eyeglasses? Yes No Distance Reading Bifocal

Do you currently wear contact lenses? Yes No Gas Perm Hard Soft Disposable
Daily Wear Extended Wear

Any Allergies? _____

Current Eye Medication(s): _____

Family History of eye Disease: _____

General Medical History: _____

Current General Medication(s): _____

Contact Lens Fees Most insurance carriers will not cover procedures related to contact lenses unless they are medically necessary. Most contact lenses are for cosmetic purposes. Please ask us for a quote of these additional fees.

Assignment of Benefits I request that payment of authorized Medicare or other assigned insurance be made Directly to Vision North / Dr. Paul M. Cangiano, O.D. any services rendered. I authorize this holder of medical information about me to release to CMS and agents and information to determine these benefits payable for related services.

If patient is under 18 years of age, guarantor (person responsible for payment) is:

Name _____ Address _____

I understand that I am responsible for any non-covered services.

Signature of Patient _____ Date _____
(Parent / guardian, if under 18)

NOTICE OF PRIVACY PRACTICES

I acknowledge that I been provided a copy of the Notice of Privacy Practices.

Signature of Patient _____ Date _____
(Parent / guardian, if under 18)