Mullins Vision
ASSOCIATES

Patient Registration Form

Date:_____ **Have you been to this office before: Yes No**

Sex:(circle) Male Female

Name:(first)_____(middle)_____(last)_____

Address:_____City:_____Zip Code:_____

Home Phone:( )_____ Date of Birth:_____/_____/_____

Race (circle one):Caucasian African American Asian Hispanic Native Hawaiian American Indian

Ethnicity (circle one): Not Hispanic Hispanic Native Hawaiian

Spouse Name(If applicable)_____ Spouse #:(_____)

Patient Employer:_____ Work#:( )_____

Emergency Contact:_____ Phone:( )_____

PLEASE PROVIDE YOUR INSURANCE CARDS TO BE COPIED AT TIME OF VISIT

Primary Insurance:_____

Member's Name:_____ Member's Date of Birth: _____/_____/____

Member's SSN:_____

Secondary Insurance:_____

Responsible Party's Information (if other than self)

Name:_____ SSN:_____

Address:_____ City:_____ Zip Code:_____

Phone:_____ Relationship:_____

I authorize Ralph H. Mullins O.D. , Stephen R. Mullins O.D, and Deanna Apple O.D. of Mullins Vision Associates, PLLC to treat me/the patient and to release any information acquired in the course of the examination and treatment to secure payment of claims and benefits. I understand that Mullins Vision Associates, PLLC policy requires payment at time of service unless other arrangements are made. I authorize payments directly from my insurance company to Mullins Vision Associates, PLLC (Ralph H. Mullins O.D., Stephen R. Mullins O.D., and Deanna Apple O.D.). I agree to be responsible for any deductibles, co-pays, coinsurance, and services rendered that are not covered by my insurance plan.

Please sign both lines below:

1.)Signature of Patient or Responsible Party:_____Date:_____

I have received Mullins Vision Associates, PLLC's Notice of Privacy Practices,

2.)Signature of Patient or Responsible Party:_____Date:_____