



# Mullins Vision

A S S O C I A T E S

## Patient Registration Form

Date: \_\_\_\_\_

Have you been to this office before: Yes No

|   |                             |
|---|-----------------------------|
| Name:(first) _____ (middle) _____ (last) _____  |                             |
| Address: _____  | City: _____ Zip Code: _____ |
| Home Phone:( ) _____  | Social Security #: _____    |
| Date of Birth: ___ / ___ / ___ Marital Status(circle) Married Single Divorced Widowed |                             |
| Sex:(circle) M F Spouse Name _____ Spouse work #:( ) _____                            |                             |
| 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. and Stephen R. Mullins 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. and Stephen R. Mullins O.D.). I agree to be responsible for any deductibles, co-pays, coinsurance, and services rendered that are not covered by my insurance plan.

Signature of Patient or Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

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

Signature of Patient or Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_