Beaufort Vision Clinic Confidential Patient Registration

Welcome to our practice, we hope your visit is a pleasant one.

INSTRUCTIONS

If you are a new patient please complete the entire form. If you are an established patient, review your information & check the box below. If possible please print & complete and return this form prior to or at the time of your visit so we may enter your data in our computer and verify your insurance.

Address	Web Site	E-mail	Fax	Phone
300 Campen Rd Beaufort ,NC 28516	www.beaufortvision.com	bvc.beaufortvision.com	252-838-0013	252-838-8822

( ) **My information has not changed** ( ) **My information needs to be updated**

Patient information required by Insurance Carriers

Mr. Mrs. Ms. Dr. Rev.	First Name	Middle Initial	Last Name	Sr. Jr. III.	Date

DOB-(MM-DD-YY)	Age	Gender	Race	Name Preference	Referral Source	Home Phone

Social Security	Status: Single, Married, Other	Occupation / Student	Work Phone	Cell Phone

Mailing Address	City	State	Zip Code

Physical Address ( ) Same	City	State	Zip Code

Name of Emergency Contact	Relationship	Emergency Contact Phone Number	Your E-Mail Address

Method of Payment and Insurance Information

Routine Vision Exams	Medical Related Eye Problems	Method of Payment: Cash Check or Card
( ) Self Pay –No Vision Insurance	( ) Self Pay- No Medical Insurance	

Vision Plan	Primary Medical Insurance	Secondary Medical Insurance

Policy Group Number or Copy of Card *	Policy Group Number or Copy of Card*	Policy Group Number or Copy of Card*

Name of Sponsor or Insured	Sponsor's ID or SS#	Gender	Sponsor's DOB	Name of Employer or School

Sponsor's Address	City	State	Zip Code	Telephone

Patient's Relationship to Sponsor				Is the Patient's Condition Related to:			Office Use Only
( ) Self	( ) Spouse	( ) Child	( ) Other	( ) Auto Accident	( ) Employment	( ) Other Accident	

WELCOME TO OUR PRACTICE

Thank you for choosing our practice for your eye care needs. Our goal is to provide you with exceptional quality of care. Our practice has an emphasis in early detection and prevention of sight threatening conditions and we are one of the most technologically advanced practices in the area. We also have a network of eye care specialists and ophthalmologist readily available if their services are required. My staff has promised to do all they can to insure that your experience in our office is a pleasant one. If you ever have a concern about your eye care, insurance, billing statement, product orders or any other questions please feel free to ask one of them. We are dedicated to your satisfaction.

PERMISSION TO FILE YOUR INSURANCE

I authorize Insight Optometric Services, PA (DBA Beaufort Vision Clinic) to release any information, including diagnosis and records of treatment and examination rendered to me or my dependents, to health care practitioners and third party payers. I authorize my insurance carrier to pay directly to IOS/BVC . I agree to accept financial responsibility for all services rendered on behalf of myself or my dependents. I understand that after IOS/BVC has settled with my insurance carrier, any unpaid balance is my responsibility.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT INFORMATION

Insight Optometric Services, PA (DBA Beaufort Vision Clinic) does not sell our patient's private information, Nor do they release it without the patient's permission. I understand I have the right to review my records. Any patient desiring an in depth copy of IOS's HIPPA Policies may request in writing.

I ACCEPT **[ ]**

Patient (Parent, if minor) _____ **Date** _____