Gray Family Vision Center
Registration Form

Name:_______________________________________ Date:____________________
Address: ____________________________________ SS#:____________________
City, St, Zip: ________________________________ Email:___________________
Phone: _______________alt ph:___________________ DOB:____________________

Single Married Divorced Widow Employed FT/PT Student FT/PT

If minor child:
Parent/Guardian__________________________DOB/SS#:______________________

Do you have any insurance that we will be billing for your visit?______________________
Insurance Co name:____

What is the reason for your visit today?_____________________________________

Whom may we thank for referring you to our office?___________________________
Friend, newspaper, internet, other

All professional services rendered are charged to the patient. Requests for payment from your insurance company will be submitted; however you are responsible for all fees, regardless of insurance coverage. Any check returned for insufficient funds shall be subject to a $25.00 returned check fee. Should your account be delinquent, a collection charge (35%) may be added to the outstanding balance. We ask for payment when services are rendered unless other arrangements have been made in advance.

I hereby authorize Gray Family Vision Center, P.A., Dr. David Guiseley and/or Dr. Jonathan Cook to furnish information to my insurance carrier(s) concerning my diagnosis and treatment.

Signature:________________________________Date:_________________________

I hereby assign to Gray Family Vision Center, P.A., Dr. David Guiseley and/or Dr. Jonathan Cook all payments for vision/medical services rendered to me and/or my dependants. I understand that I am responsible for any balance not covered by my insurance.

Signature:________________________________Date:_________________________

I acknowledge that I received a copy of Gray Family Vision Center, P.A.'s Notice of Privacy Practices.

Signature:________________________________Date:_________________________