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:_____