

Mark H. Williams, O.D.
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Doctors of Optometry

Patient Registration

WELCOME

THANK YOU FOR CHOOSING OUR OFFICE FOR YOUR EYECARE

Today's Date _____ Date of Birth _____

Patient Name Mrs. Ms. Miss
(Circle) Mr. Dr. _____

Address _____

City _____ Zip _____

Home Phone _____ Work or Cell _____

If Child _____ School Attending _____
Parent Name _____

Occupation _____ Employed By _____

Email: _____

Referred to our office by _____

Social Security # _____

Insurance Information: Circle Yes or No for each

•Vision Insurance Yes No Carrier's Name _____

If you are not the member, member's name _____

Member's Social Security _____ Date of Birth _____

•Medical Insurance Yes No Carrier's Name _____

•Medicare Yes No Medicare # _____

Office policy for payment:

A deposit is required on the day of service and the balance is paid on the day of delivery. If the above policy is not followed, a service charge will be added to all accounts over 30 days.

HIPAA ACKNOWLEDGEMENT

I acknowledge that I have received notice of privacy practices as required by HIPAA privacy standards. Copy posted in waiting room. Copies available.

Signature _____