Circle of Life Eyecare New Patient Registration Form

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can and don't hesitate to ask for assistance if you have any questions. (Please Print)

Today's Date:	Patient ID (Office Use Only):

Patient Information

Name: Last First Middle	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	SSN (Social Security #):	Birth Date (mm/dd/yy):	Age:	Sex: ☐ M ☐ F

Address: Street/P.O.Box	Home Phone:
Address (cont.):	Work Phone:
City, State, Zip Code:	Cell Phone:

Occupation:	Employer/School:	Email (For office reminder, recall, etc):

Spouse/Parents Name:	SSN:	Birth Date:
S/P Employer:	Work Phone:	Cell Phone:

Insurance Information

(Please give vision and medical insurance card to receptionist to be scanned into your records)

Is this visit ☐ Self pay Covered by ☐ Vision insurance ☐ Medical insurance

Please indicate primary vision insurance	☐ VSP	☐ EyeMed	☐ Spectera	☐ Davis Vision/Fed Blue	☐ Avesis	☐ Other

Subscriber's Name:	Birth Date:	Subscriber's SSN:	Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Is subscriber also a patient in our office?	☐ Yes	☐ No	If not when was the last eye exam?

Please indicate primary medical insurance	☐ Medicare	☐ Medicaid	☐ BCBS	☐ Aetna	☐ Cigna	☐ Other

Subscriber's Name:	Birth Date:	Subscriber's SSN:	Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name of additional vision and/or medical insurance (if applicable)	Subscriber's name:	Birth Date:	Subscriber's SSN:

Authorization # (Office use only)	Exam Co-pay	Lens Co-pay	Frame Allowance	Other Lens Option	CL Allowance	Note:

Emergency Contact

Name of local friend or relative (not living at the same address)	Relationship to patient:	Home phone:	Work phone:	Cell phone:

Authorization of Optometric Services/Assignment of Vision and Health Insurance Benefits/ Privacy Practice Acknowledgement

I hereby authorize Dr. Ruthie Ruan, O.D., to examine, diagnose, treat and manage my eye health and vision condition. I hereby assign all vision and health insurance benefits to Dr. Ruthie Ruan, O.D. for all services rendered and materials furnished. This assignment includes benefits payable by vision plans, Medicare, Medicaid, Medigap, and all other health insurance program of which I am a beneficiary. I acknowledge that I have received a copy of Notice of Privacy Practices from Dr. Ruthie Ruan, O.D. and I have been provided an opportunity to review it.

Patient/Guardian Signature _____ Date _____