Icare Optical

Registration Form

Today's Date:

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:

Birth Date:	Age:	Sex: ❒ M ❒ F	Social Security #:

Street Address:	P.O. Box:	Home Phone #:
City:	State:	ZIP Code:
E-mail Address:		Cell Phone #:

Referred to Clinic by: ❒ Dr. ❒ Insurance Plan ❒ Hospital ❒ Website ❒ Family/Friend

❒ Close to Home/Work ❒ Online Search ❒ Social Media ❒ Other

LEGAL GUARDIAN/ CARETAKER

Name:	Address (if Different):
Birth Date:	Home Phone #:

Patient's Relationship to Subscriber: ❒ Self ❒ Spouse ❒ Child ❒ Other

INSURANCE INFORMATION

(Please Give Your Insurance Card to the Receptionist)

Subscriber Name:	Address (if Different):	Home Phone #:
Subscriber's Social Security:	Policy # / ID #:	Birth Date:

Patient's Relationship to Insurance Subscriber: ❒ Self ❒ Spouse ❒ Child ❒ Other

IN CASE OF EMERGENCY

Name of Friend or Relative:	Relationship to Patient:	Cell Phone #:	Work Phone #:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Icare Optical or my insurance company to release any information required to process my claim.

_____ _____

Patient /Guardian Signature *Date*