

Samuel L. Weir, O.D.  
Shannon Moore, O.D.  
Lisa Butterfield, O.D.

**PATIENT REGISTRATION FORM**  
**PLEASE PRINT**

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ Nickname \_\_\_\_\_

Please Check One:  Mr.  Mrs.  Ms.  Miss  Dr.

Home Address \_\_\_\_\_

Street (or) Rural Route & Box Number

\_\_\_\_\_

City

\_\_\_\_\_

State

\_\_\_\_\_

Zip Code

Date of Birth \_\_\_\_\_ Ethnicity  Non-Hispanic  Hispanic Sex  M  F

Race  American Indian  Asian  African American/Black  Native Hawaiian  
 White/Caucasian  Native American  Refuse to Specify  Not Disclosed

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Employer \_\_\_\_\_ E-mail \_\_\_\_\_

(Employed Adults)

Occupation \_\_\_\_\_ Social Security # \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Preferred Language \_\_\_\_\_

If we have visual records of members of your immediate family, please list them here

**COMPLETE THIS SECTION IF PATIENT IS UNDER 18**

\_\_\_\_\_

Full Name of Parent or Responsible Party

\_\_\_\_\_

Relationship

\_\_\_\_\_

Responsible Party's Employer

\_\_\_\_\_

Work Phone Number

\_\_\_\_\_

School

\_\_\_\_\_

Grade

\_\_\_\_\_

Teacher's Name

Approximate date of last eye examination \_\_\_\_\_

Is this your first visit to this office?  YES  NO

Who may we thank for referring you to us? \_\_\_\_\_

Account will be paid by  Check  Cash  Visa  Master Card  
 Discover  American Express  ATM Card

- **When necessary, I authorize Dr. Weir, Dr. Moore and Dr. Butterfield to release information** pertaining to my vision, health of the eye, advice, treatment or supplies to other optometrists, physicians, opticians or to my insurance carrier. I reserve the right to withdraw this authorization in writing at any time.
  
- **Professional fees are due when services are rendered.** A deposit of half the total charges is required before materials can be ordered. The balance is due when materials are dispensed.
  
- **Our policy for patients who carry health care insurance is the same as above.** We will be glad to give you an “insurance copy” of your statement or fill out and submit your insurance form for you. Any other arrangements must be made in advance.
  
- Most insurance policies pay only a portion of your total charges. **If you have questions about your coverage, please contact your representative.** We do not guarantee the accuracy of benefit information given to us by insurance companies! Please understand that financial responsibility for your account is yours, not your insurance company’s.
  
- There will be a **\$25.00 fee** applied to account balances **for returned checks.**
  
- **Delinquent accounts will be turned over to an attorney for collection.** All legal fees and court costs shall be the responsibility of the patient and/or guarantor.
  
- I request that **payment under my insurance plan** be made either **to me or on my behalf to Samuel L. Weir, O.D., P.C.** for any services furnished by the provider.

I have read and understand all of the above.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship to patient