Shannon J. Moore, O.D.
Lisa Butterfield, O.D.
Barbara Masiello, 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. Moore, Dr. Butterfield and Dr. Masiello 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 Shannon Moore, 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