

PLEASE FILL OUT THE ENTIRE FORM WITH ALL THE REQUESTED INSURANCE INFORMATION

Ani Halabi O.D.
 Doctor of Optometry, P.C.
 DEA#: MH1296739
 License #: OPT12807TPL

PATIENT REGISTRATION FORM

** Specialty Contact Lens Fittings * LASIK Consultation * Ocular Disease Treatment * Comprehensive Eye Exams **

1. PATIENT INFORMATION			Date:		
LAST NAME		FIRST NAME		M.I.	
HOME STREET ADDRESS		CITY		STATE ZIP	
HOME Phone #		CELL Phone #		WORK Phone #	
OCCUPATION		NAME of PARENT OR GUARDIAN if patient is minor (19 years old and under)			
<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> MINOR		SOCIAL SECURITY NUMBER			
EMAIL		DATE OF BIRTH		AGE <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	

2. INSURANCE	
VISION INSURANCE	MEDICAL / OTHER INSURANCE (PPO Only)
INSURANCE COMPANY	INSURANCE COMPANY
ID#	ID#
PRIMARY CARDHOLDER	SUPPLEMENT INS. (if any)
PRIMARY'S SSN#	PRIMARY CARDHOLDER NAME
PRIMARY'S DATE OF BIRTH and RELATIONSHIP TO PATIENT	PRIMARY'S DATE OF BIRTH and RELATIONSHIP TO PATIENT

INSURANCE ASSIGNMENT AND RELEASE: I certify that I, and/or my dependent(s), have insurance coverage as described above and assign directly to Ani Halabi, O.D. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient/Guardian Signature: _____ Date _____

If Minor, Print full name of Parent or Guardian: _____

3. PRIVACY PRACTICES
I acknowledge that I have read and fully understand the "Notice of Privacy Practices" given to me with this form. I understand I can receive a copy upon request.
Patient/Guardian Signature: _____ Date _____

4. PLEASE LET US KNOW
HOW DID YOU FIND US?
WHOM MAY WE THANK FOR REFERRING YOU?