Gray Family Vision Center
Registration Form

Name:____ Date:______________________
Address: ____ SS#:______________________
City, St, Zip: ____ Email:_____________________
Phone: ___________________alt ph:____________________ DOB :_____________________
Primary Care Physician:_______________________________
Single Married Divorced Widow Employed FT/PT Student FT/PT

If minor child:
Parent/Guardian_______________________________DOB/SS#:___________________________

Do you have any insurance that we will be billing for your visit?__________________________
Insurance Co name:____

What is the reason for your visit today?____

All professional services rendered are charged to the patient. We ask for payment when services are rendered unless other arrangements have been made in advance. Requests for payment from your insurance company will be submitted; however you are responsible for all fees, regardless of insurance coverage. ***Any check returned for insufficient funds shall be subject to a $25.00 returned check fee. Should your account be delinquent, a collection charge (25%) will be added to the outstanding balance.***

I hereby authorize Gray Family Vision Center, P.A., Dr. David Guiseley and/or Dr. Jonathan Cook to furnish information to my insurance carrier(s) concerning my diagnosis and treatment.

Signature:_____________________________________Date:______________________________

I hereby assign to Gray Family Vision Center, P.A., Dr. David Guiseley and/or Dr. Jonathan Cook all payments for vision/medical services rendered to me and/or my dependants. I understand that I am responsible for any balance not covered by my insurance.

Signature:_____________________________________Date:______________________________

I understand that if the terms of my health care coverage requires a referral for this examination, I am responsible for obtaining the referral. If I fail to obtain the referral I will be responsible for all charges related to this examination.

Signature:_____________________________________Date:______________________________

I acknowledge that I received a copy of Gray Family Vision Center, P.A.'s Notice of Privacy Practices.

Signature:_____________________________________Date:______________________________

Jonathan F. Cook, OD John M. Hamilton, OD David L. Guiseley, OD