



Michael G. McGrath, O.D.
Optometric Physician

WELCOME

We're pleased and proud that you have chosen our office. In the interest of establishing a thorough and accurate record for your file, we respectfully ask that you complete all applicable portions of this patient registration form. Please ask a staff member if you need assistance or have any questions.

Patient's Name (First, M.I., Last) _____ Today's Date _____

Preferred "Nickname" _____ Occupation _____

Birthdate _____ Age _____ Sex M F Social Security Number _____

Mailing Address _____ Home Phone _____

_____ Work Phone _____

Personal Physician(s) _____

Primary reason(s) for this visit _____

Approx. date of last complete eye exam _____ Previous eye Dr. _____

If child: Grade _____ School _____ Teacher (grade 6 & under) _____

Whom may we thank for referring you to us? _____

Household Member Responsible for Account: (First, M.I., Last) _____

Mailing Address _____ Home Phone _____

_____ Work Phone _____

Employer/Business _____ Occupation _____

Social Security Number _____ Relationship to Patient _____

Spouse Name _____ Occupation _____

Employer/Business _____ Work Phone _____

Please list any members of your household who come to our office: _____

About our Financial Policies

Our practice participates in many major insurance plans, and our staff will gladly assist you in obtaining proper reimbursement from your vision and/or major medical plans. In general, routine vision exams and optical materials are covered by vision plans; office visits or exams for other eye problems are usually covered by major medical plans. Please ask if you have any questions regarding your insurance situation.

Vision Insurance? Yes No Company or Plan _____

Major Medical? Yes No Company or Plan _____

Have you ever had any injury or surgery to your eyes? Yes No Describe _____

Are you allergic to any medications? Yes No List _____

Do you presently wear glasses? Yes No Contact Lenses? Yes No Type _____

Please Note: Insurance may cover only part of your charges. If we do not accept direct payment from your insurance plan, you will need to pay our office and submit your receipt for reimbursement from your insurance company. If your insurance does not pay as expected, you are ultimately responsible for all charges. We cannot be responsible if you are not eligible for benefits. We will be happy to assist you with your claims. Please give any forms to the receptionist.

I hereby authorize my insurance benefits to be paid directly to Woodridge Vision Clinic and I am financially responsible for non-covered services.

Signed: _____