

Overlake Family Vision  
Mary Baker, O.D.

Patient Registration  
Please Print

Date \_\_\_\_\_

**Patient Information**

Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Phone Home \_\_\_\_\_ Business \_\_\_\_\_ Cell \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Sex M \_\_\_\_\_ F \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Marital Status \_\_\_\_\_

Patient Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

In case of emergency who should be notified? \_\_\_\_\_ Phone \_\_\_\_\_

E-Mail Address \_\_\_\_\_

**Notice of Privacy Practices**

We keep a record of the health care services that we provide for our patients. You may ask to see and copy that record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

**By my signature below, I acknowledge receipt of the Notice of Privacy**

\_\_\_\_\_  
Signature of patient or authorized representative Date

\_\_\_\_\_  
Printed name if signed on behalf of patient Relationship to patient

**Assignment and Release**

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to Overlake Family Vision, PLLC 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 payment of benefits. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
Responsible Party Signature Relationship Date