Mark H. Williams, O.D.
Lynn Oku, O.D.
Doctors of Optometry

Patient Registration

WELCOME

THANK YOU FOR CHOOSING OUR OFFICE FOR YOUR EYECARE

Today's Date_____ Date of Birth _____

Patient Name Mrs. Ms. Miss
(Circle) Mr. Dr._____

Address_____

City_____ Zip _____

Home Phone _____Work or Cell _____

If Child _____School Attending _____
Parent Name

Occupation_____ Employed By_____

Email:_____

Referred to our office by_____

Social Security Last 4 # ___ ___ ___ ___

Insurance Information: Circle Yes or No for each
- **Vision Insurance Yes No Carrier's Name_____**

If you are not the member, member's name_____
Member's SSN last 4 _____ Date of Birth_____
- **Medical Insurance Yes No Carrier's Name_____**
- **Medicare Yes No Medicare # _____**

Office policy for payment:
A deposit is required on the day of service and the balance is paid on the day of delivery. If the above policy is not followed, a service charge will be added to all accounts over 30 days.

HIPPAA ACKNOWLEDGEMENT
I acknowledge that I have received notice of privacy practices as required by HIPAA privacy standards. Copy posted in waiting room. Copies available.

Signature_____