PINES VISION CARE
NEW PATIENT REGISTRATION FORM
Dr. Stuart McIver | Dr. Liliana Betancourt

We require payment in full/or insurance co-pays at the time services are rendered or eye wear is ordered. We accept cash, Visa, Master Card, American Express and Care Credit.

Last Name: _____ First Name: _____ MI: ____

Social Security: _____-____-_____ Birth Date:_____ Gender: *M F*

Address: _____ E-mail Address: _____

City: _____ State: ___ Zip: _____ Occupation: _____

Cell: (____)_____-_____ Alternate: (____)_____-_____ Employer: _____

Insurance Information:

Do you have Health/Medical Insurance? *Yes No*
If Yes: Name of Insurance Company: _____
Policy Holders Name: _____
Policy Holder Social Security No. _____-____-_____
Policy Holder Birth Date _____
Policy Holder Employer _____

Do you have VISION insurance? *Yes No*
If Yes: Name of Insurance Company: _____
Policy Holders Name: _____
Policy Holder Social Security No. _____-____-_____
Policy Holder Birth Date _____

Please give your Picture Id/ Drivers License and your insurance card to the receptionist.

How did you hear about us? (Circle all that apply)
Walk-In Insurance Manual Search Engine Our website YELP
Friend/Family: _____
Doctor's Office Name: _____

Please be advised that "No Show" appointments or "No Call to Cancel" an existing appointment will result in a $15 charge. Kindly call at least 24 hours PRIOR, or 48 hours for Saturday appointments, if you need to reschedule. Thank you.
INIITIAL HERE_____