Ohio Vision, LLC

John J. Wilding, D.O.
William E. Schemmel, O.D.

Patient Registration

Date _____

Name _____ Social Security # _____
Last *First* *MI*

Address _____ City _____ State _____ Zip Code _____

Birth date ____/____/____ Age ____ Sex: M F Status: Married___ Single___ Divorced___ Widowed___

Phone: *Home* _____ *Work* _____ *Cell* _____ Email: _____

The following information is being collected per Federal Government regulations in the Health Information Technology Act (HITECH ACT). Your response is optional.

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ More than one
☐ Native Hawaiian or Pacifica Islander ☐ White ☐ Unreported/Unknown

Preferred Language _____ **Ethnicity**: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Decline

Employer _____
Name *Address*

Spouse _____ Social Security # _____ Birth date ____/____/____

Spouse's Employer _____
Name *Address*

Emergency Contact _____Relationship_____ Emergency Phone_____

Person Financially Responsible (if other than self)_____
Last *First* *MI*

Street _____ City _____ State _____ Zip Code _____

Relationship to Patient: Spouse _____ Parent _____ Guardian _____ POA _____ Other _____

Primary Insurance _____ _____ _____ _____ ___/___/___
Insurance Name | Policy Holder | Policy ID | Insured's: *SS#* *If different than patient* | *DOB*

Secondary Insurance _____ _____ _____ _____ ___/___/___
Insurance Name | Policy Holder | Policy ID | Insured's: *SS#* *If different than patient* | *DOB*

_____ _____ _____
Family Doctor | Address | Phone

_____ _____ _____
Family Optometrist | Address | Phone

Who may we thank for telling you about our practice? _____

FINANCIAL AND MEDICAL POLICY (APPLICABLE TO ALL PATIENTS)

Your health insurance policy is an agreement between you and your insurance carrier for reimbursement of fees paid to the physician and is usually not designed to pay the entire fee. Regardless of your medical coverage, we rely on you for settling your account. You are ultimately responsible for all office and surgery fees relating to your care. If we have a problem collecting from your insurance company, we will ask you to become involved. Whatever service your insurance does not cover, you will be responsible for payment.

I authorize the release of any medical information necessary to process this claim and I authorize the release of payment for medical benefits to my physician.

I understand and agree with the above statement: _____ _____
Patient signature (Required) | Date

PLEASE CHECK ☐ if you give permission to Ohio Vision to discuss your medical care with any other person please provide their name(s), phone number and relationship to patient

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