Winston Eye Care

101 Laguna Road Ste. C
Fullerton CA 92835-3637
www.winstoneyecare.com

(714) 888-2080
(714) 888-2099

Patient Registration

Please review, make necessary changes and supply any missing information.

Patient Name				Salutation (Mr. Ms. Mrs. Dr.)	
Date of Birth		Age		State You Were Born	
Sex				SS #	
Address					

Communication					
Home Phone #		Work Phone #		Extension	
Cell Phone #		Preference			
Patient Portal allows you to view your visit summary and connect with your doctor online.					
Patient Portal (circle one): Yes / No		Email:			
If you selected no, please select a reason:	[ ] Limited or no access to a computer/internet. [ ] I do not have an email address. [ ] Other or not interested.				

Account Responsible					
Responsible		Salutation		Date of Birth	
Relationship		SS #			
Address					
Home Phone #		Work Phone #		Ext.	
Email					

Emergency Contact

Sal	First	M	Last	Relation	Home#	Cell#	Work#	Ext

Authorization to Pay Benefits to Physician

I, undersigned, assign directly to Jeffrey V. Winston, M.D., Inc. 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 understand that I may be charged a $25 fee if I do not notify Winston Eye Care of any cancellations 24 hours prior to my scheduled appointment. If I am fitted with contacts, I understand that I will be charged $75 as an established patient, or $125 as a new patient. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions. I have added or corrected all of the information on this document.

______________________________ Signature

________________ Date