Charles W. Stine O.D., P.C.

4 Pendleton Street, P.O. Box 1360
Middleburg, VA 20118
540-687-3634

Patient Registration

Date: _____

Patient Name: _____ Date of Birth: _____

Last First MI

Address: _____ Sex: M_____ or F_____

_____ Home Phone: _____

City State Zip

Patient Social Security #: _____ Cell Phone: _____

If Minor Responsible Party: _____ Phone: _____

Address if Different: _____ Relationship to Patient: _____

Do you wish to receive email reminders: _____ email address: _____

Insurance Information

Primary Insurance: _____ Insured Employer: _____

Insured Name: _____ Date of Birth: _____

Insured Social Security #: _____ Employer: _____

Address if Different: _____ Relationship to Patient: _____

*** Please be aware of your Insurance. HMO and some POS plans require a referral. If you are here for any reason other than for glasses and or contacts you may need a referral from your primary care doctor. If you do not provide a referral at the time of your visit, you may be billed.**

I request that payments of authorized Medicare and/or above stated insurance be made to Middleburg Eye Center and all related parties for any services furnished to me. I understand that some services provided are not covered by my insurance companies and I agree to pay for such services as well as any copay amounts designated by my insurance. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand that an EYE EXAM includes a routine eye examination and a prescription for glasses. It does not include contact lens fitting, corneal measurements or contact lens specifications and such fittings will result in an additional charge.

In all cases professional fees are the patient, guardian and /or parents responsibility. A $10.00 late fee will be added to all accounts more than 30 days past due. Patient or responsible parties further agree to pay any and all collection fees incurred and legal expenses, including but not limited to Collection Agency and attorney fees, court expenses, service and filing fees.

* HIPPA privacy notice has been received.

Patients/Insured Signature: _____ Date: _____

*** Please be aware, our office will retain records for seven years from the last date of service.**