Dr. Dan Perala
2528 Dell Range Blvd
(307) 634-2503
appointments@anceyecare.com

Patient Registration

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

Patient Name	First		Middle		Last			Salutation	
DOB		Age						State of Birth	
Sex								SS #	
Address									
Address Type								Country	

COMMUNICATION					
Preference					
Home Phone #		Work Phone #		Extension	
Cell Phone #		Email			

INFORMATION			
Primary Language		Special Needs	
Race		Ethnicity	
Marital Status		Mother's Maiden Name	
Occupation		Employer	

ACCOUNT RESPONSIBLE					
Responsible				Salutation	
Relationship		DOB		SS #	
Address					
Home Phone #		Work Phone #		Cell Phone	
Email					

PRIMARY INSURANCE			
Name		Group Name	
ID #		Group #	
Address			
Phone			
Insured		Date of Birth	

SECONDARY INSURANCE			
Name		Group Name	
ID #		Group #	
Address			
Phone			
Insured		Date of Birth	

EMERGENCY CONTACT RELEASE OF MEDICAL INFORMATION – STATUS

Sal	First	MI	Last	Relation	Home#	Cell#	Address	City	State	Zip Code

Form of Payment (Circle One): Cash Check Credit/Debit Insurance

initials
*_______ We file insurance as a courtesy and benefit information is not a guarantee of payment. If for any reason your insurance company does not pay for the office visit and/or services, the balance is your responsibility.

initials
*_______ I (responsible party) understand a **$35.00** Finance Charge will be imposed on the outstanding balance in the event
the account is turned over to a collections company.

I authorize the release of any information necessary to process my insurance claims and assign and request payment directly to Dr. Daniel Perala/A New Concept Optical & Eyecare.

ACKNOWLEDGEMENT OF RECEIPT
I acknowledge that I have been informed of and may receive a copy of **Dr. Daniel R Perala OD.** Notice of Privacy Practices.

Signature____ Relationship to Patient______________________________

Date_________________________________