Dr. Dan Perala
2528 Dell Range Blvd.
Cheyenne, WY 82009-5273

appointments@anceyecare.com

Patient Registration

April 20, 2022
Please review, make necessary changes and supply any missing information.

Patient Name	**First**		**Middle**		**Last**			**Salutation**	
DOB		**Age**						**Place of Birth**	
Sex								**SS #**	
Address									
Address Type	Home							**Country**	UNITED STATES

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

INFORMATION			
Primary Language	English	**Special Needs**	
Race		**Ethnicity**	Not Hispanic or Latino
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

I understand that, although a New Concept Optical & Eyecare submits insurance claims to indicated carriers as a professional courtesy to facilitate such payments, it should not be considered a guarantee of resolution, and any balance left unpaid by my benefit carriers is my responsibility. I agree that in the event of non payment of any amounts due, I will pay interest thereon at the rate of 1.75% per month (21% per annum) and pay all reasonable attorney fees and court costs. I also agree that in the event this agreement is assigned to an agency for collection, I promise to pay an additional collection fee of 35% of the unpaid balance due.

Signature_____Date_____

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_____

Please bring your medical and vision insurance information with you, along with any medications.