Eye Specialists

PATIENT REGISTRATION FORM

Patient name:_____ **Today's date:**_____
Last **First** **Middle**

Home address: _____

City: _____ **State**: _____ **Zip code:** _____

Home phone: _____ **Cell phone:** _____

E-mail address: _____ **Marital status:** Single Married Divorced Widowed

Date of birth: _____ **Age:** _____ **Gender**: M F

Employer: _____ **Occupation:** _____

Work Address: _____ **Work Phone:** _____

City: _____ **State:** _____ **Zip Code:** _____

Spouse name (parent name if minor): _____

Spouse/parent work phone: _____

Emergency contact name/relationship: _____

Emergency contact number: _____

Referred by:_____ **Primary care physician:**_____

Primary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		**Relationship to Patient**
Social Security Number	Date of Birth	Employer

Secondary Insurance Company		
ID#	Group #	Effective Date

Subscriber Name		**Relationship to Patient**
Social Security Number	Date of Birth	Employer

I certify that I (or my dependent) have insurance coverage as stated above and agree to have insurance payments made directly to (Practice Name) to be applied to my account for services rendered. I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment. I am aware there may be additional collection and/or attorney's fees if my account is referred for collection. For patients covered by Medicare the patient will be responsible for 20% of the Medicare allowable charges plus any deductibles, coinsurance and uncovered charges that apply.

_____ _____

Patient's signature **Today's date**

Pharmacy: _____ **Address:** _____

City/State: _____ **Phone:** _____

Physician information:

Other physician's name and specialty **Address/phone number**

Other physician's name and specialty **Address/phone number**

AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION:

I authorize my physician and/or administrative and clinical staff of Eye Specialists to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices.

Name and relationship of person(s) who you wish to allow access: (e.g., your spouse, son, daughter, sibling, caretaker, friend)

Name of Person or Entity: **Relationship:**

I have been provided a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to read and understand and consent to use and disclosure of protected health information about myself for treatment, payment and health care operations.

_____

Patient or patient representative signature

I have been provided a copy of the Financial Policy to read. I understand, that I, the patient or the patient's representative, am/is responsible for payment of all charges for service rendered. I also acknowledge that non-payment of my account may result in collections proceedings and dismissal from the practice.

_____

Patient or patient representative signature

I authorize the release of any medical information necessary to process all claims and I authorize the release of payment for medical benefits to Eye Specialists

_____

Patient or patient representative signature