PATIENT REGISTRATION FORM

Abrams EyeCare ASSOCIATES

****** Please print and fill in all information on both sides of this form******

We apologize for the line of questions that are now required by the Government

Patient Information

Last Name:	First Name:		Middle:
Address:	City:	ST:	ZIP:
DOB:	SS#:	Marital: S / M / W / D	Sex: F / M

Language: _____ **Ethnicity:** ☐ Hispanic ☐ Non Hispanic ☐ Unknown **Refused, please initial**_____

Race: _____ **or** ☐ African American ☐ White ☐ Native America ☐ Asian ☐ Pacific Islander ☐ Unknown **Refused, please initial**_____

Contact Information - Please check mark your preferred method of contact		May we send appointment reminders to your preferred choice? **YES / NO**	
Home ( )	Work ( )	Cell ( )	Email _____

I authorize my physician's office to call and leave a voicemail in regards to appointment reminders and call back request with a family member. INITIAL_____

Occupation:	Employer:	Phone ( )	
Employer Address:	City:	ST:	ZIP:
Referring Physician:	Phone ( )		
Address:	City:	ST:	Zip:
Primary Care Physician (PCP):	Phone ( )		
Address:	City:	ST:	Zip:

Primary Medical Health Insurance

(Please provide your insurance card to front desk at the time of check in)

Insurance Name:	Policy / Group ID:	**Is Patient the Subscriber? YES / NO**	
Subscriber Name:	DOB:	SS#:	Phone ( )
Employer Name:		Phone ( )	
Address:	City:	ST:	Zip:

Secondary Medical Health Insurance

(Please provide your insurance card to front desk at the time of check in)

Insurance Name:	Policy / Group ID:	**Is Patient the Subscriber? YES / NO**	
Subscriber Name:	DOB:	SS#:	Phone ( )

Primary Vision Insurance

(Please provide your insurance card to front desk at the time of check in)

Insurance Name:	Policy / Group ID:	**Is Patient the Subscriber? YES / NO**	
Subscriber Name:	DOB:	SS#:	Phone ( )
Employer Name:		Phone ( )	
Address:	City:	ST:	Zip:

Secondary Vision Insurance

(Please provide your insurance card to front desk at the time of check in)

Insurance Name:	Policy / Group ID:	**Is Patient the Subscriber? YES / NO**	
Subscriber Name:	DOB:	SS#:	Phone ( )

Guarantor / Legal Guardian

Please Complete if Different from Patient

☐ Parent	☐ Legal Guardian	☐ Other
Last Name:	First Name:	Relationship:
Home Phone ( )	SS#:	DOB:

Address:	City:	ST:	Zip:

Emergency Contact

Note: Different from your home information

Full Name:	Relationship:
Home Phone ( )	Work Phone ( )

How did you find out about Abrams EyeCare Associates?

☐ Family / Friend / Relative	☐ Yellow Pages
☐ Other Healthcare Provider	☐ Our Website
☐ Other (Specify):	☐ Search Engine (Google, ect./Specify):

Patient / Guarantor Signature:	Date:

All the information provided above is complete and accurate to the best of my knowledge

Photo ID, insurance card and co-pays are required on day of visit. If you did not bring insurance cards with you, all charges will be your responsibility and payable at the time of service.
Obtaining required referral forms and treatment pre-certification is the patient's responsibility.
All unpaid balances and or denied claims are the responsibility of the Guarantor / Legal Guardian.

Divorced Parents: It is our policy that the parent accompanying the child for treatment will be held responsible for all charges.

HIPAA Privacy Notice

Patient Name:_____
(Please Print)

I acknowledge that I have received a copy of
Notice of Health Information Practices: A Message to Our Patients and Their Families.

Patient/Guarantor Signature:_____

Date:_____ **Witness:**_____