



PATIENT REGISTRATION

TODAYS DATE:

| PATIENT INFORMATION | | LAST NAME | FIRST NAME | MIDDLE INITIAL |
|---------------------------------------|--|---------------------------------------|-------------------------|----------------|
| ADDRESS | | CITY | STATE | ZIP |
| HOME TELEPHONE: | PERMANENT ADDRESS IF DIFFERENT FROM ABOVE: | | | |
| DAYTIME PHONE: | MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE | DATE OF BIRTH: | SOCIAL SECURITY NUMBER: | SEX |
| MOTHER'S NAME (If patient is a minor) | | FATHER'S NAME (If patient is a minor) | | |

| SPOUSE OR GUARDIAN | | LAST NAME | FIRST NAME | MIDDLE INITIAL |
|---------------------------|-------------------------|---|-------------------------|----------------|
| ADDRESS | | CITY | STATE | ZIP |
| HOME TELEPHONE: | RELATIONSHIP TO PATIENT | DATE OF BIRTH: | SOCIAL SECURITY NUMBER: | SEX |
| EMPLOYER | | | | |
| EMPLOYER'S TELEPHONE: | EXT: | EMPLOYMENT STATUS: <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> RETIRED <input type="checkbox"/> SELF | | |

| PATIENT EMPLOYMENT | | EMPLOYMENT STATUS: <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> RETIRED <input type="checkbox"/> SELF |
|---------------------------|----------|---|
| OCCUPATION: | EMPLOYER | |
| EMPLOYEE'S WORK TELEPHONE | EXT: | |

PLEASE FILL OUT EVEN IF WE HAVE A COPY OF YOUR INSURANCE CARD

| PRIMARY INSURANCE | | PRIMARY INSURANCE COMPANY: |
|-------------------------------|---------------------------------|----------------------------|
| INSURED NAME: | RELATIONSHIP OF INSURED TO YOU: | |
| SUBSCRIBER ID OR MEDICARE NO: | GROUP NUMBER: | |
| SUBSCRIBER'S DATE OF BIRTH: | SUBSCRIBER'S EMPLOYER: | |

| SECONDARY INSURANCE | | SECONDARY INSURANCE COMPANY: |
|-------------------------------|---------------------------------|------------------------------|
| INSURED NAME: | RELATIONSHIP OF INSURED TO YOU: | |
| SUBSCRIBER ID OR MEDICARE NO: | GROUP NUMBER: | |
| SUBSCRIBER'S DATE OF BIRTH: | SUBSCRIBER'S EMPLOYER: | |



I authorize the release of payment and any medical information necessary to process all claims for medical benefits to my physician. If my insurance company requires a referral to see a specialist, I am fully aware that it is my responsibility to obtain a referral from my primary care doctor. I acknowledge that it is my responsibility to check with my health plan to determine that the doctor examining me is a contracted provider of my health plan. All fees, deductibles and/or co-pays must be paid on the day of service. All other arrangements must be made in advance. Despite any insurance coverage, you or your legal guardian are ultimately responsible for payment for any and all services and products provided to you. I hereby accept financial responsibility for all charges.

Patient/Parent Signature: _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Kathryn Melvin, Privacy Officer.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

| | | |
|--|-------------------------|---|
| _____ | _____ | _____ |
| Patient or legally authorized individual signature | Date | Time |
| _____ | _____ | _____ |
| Printed name if signed on behalf of patient | Relationship to Patient | (parent, legal guardian, personal representative) |

MEDICARE INSURANCE

If you are Medicare Eligible, please sign below. Both signatures are REQUIRED.

I understand that Medicare will determine if this eye examination is routine or medically necessary and may deny or reduce payment. Therefore, if Medicare does deny or reduce this claim, I will accept responsibility for payment.

Patient Signature: _____ **Date:** _____

Lifetime Authorization

I request that payment of authorized Medicare benefits be made on behalf to Island Eye Physicians & Surgeons, P.C. for any services provided to me by that physician. I authorize any holder of medical information about me be released to Health Care Financing Administration and it's agents as needed to determine these benefits payable for related services.

Patient Signature: _____ **Date:** _____