PATIENT REGISTRATION

REFERRED BY:

PHONE BOOK___ TV___ INS CO___ FRIEND___ NEWSPAPER___ ANOTHER PHYSICIAN____________________ OTHER___

Patient Name____ Gender: Male______ Female_______

Guardian Name________________________________ Relationship to Patient_______________________________

Date of Birth_______ / _______ / __________ SS#_________-__________-______________

Street Address____

City____ State____________________ Zip_______________

Home Phone (_____)_______-_______ Cell Phone(_____)_______-________ Email: _____________________

Employer Name____ Phone (_____) _______-_________

Pharmacy Name____________________________________ Pharmacy Phone (_____) ________-_______

Primary Care Physician (PCP) _______________________ PCP Phone (____) ________-________

Emergency Contact _______________________________ Phone (_____) __________-________

Is visit related to Workers Comp or No Fault incident? YES_______ NO_______

Primary Insurance Carrier ____

Policy# ____ Group# __________________________

Policy Holders Name_______________________________________ Date of Birth______________________

Policy Holders SS# (if other than patient)____

Secondary Insurance Carrier____

Policy# ____ Group# _____________________________

Policy Holders Name____________________________________ Date of Birth ________________________

Policy Holders SS# (if other than patient)____

DOES YOUR INSURANCE REQUIRE YOU TO OBTAIN A REFERRAL TO SEE A SPECIALIST?

YES_____ NO______

PLEASE BE AWARE: MANY MANAGED CARE CONTRACTS (HMO'S & PPO'S) CONSIDER "WELL-CARE" VISITS (EXAMS NEEDED TO DETERMINE THE NEED FOR EYEGLASSES OR CONTACT LENSES) AS "UNCOVERED SERVICES." THIS MEANS THAT THE PATIENT MUST PAY FOR THESE SERVICES OUT OF POCKET. IT IS THE PATIENT'S RESPONSIBILITY TO CONTACT THEIR INSURANCE COMPANY REGARDING THEIR INDIVIDUAL POLICY.
I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES RENDERED TO ME AND / OR FOR ANY BALANCE(S) TO INCLUDING BUT NOT LIMITED TO COPAYS, DEDUCTIBLES, COINSURANCES, AND ANY UNCOVERED SERVICE.

PATIENT / GUARDIAN SIGNATURE____________________________________ DATE_______________________

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION TO MY INSURANCE COMPANY NECESSARY TO PROCESS MY MEDICAL CLAIMS.

PATIENT / GUARDIAN SIGNATURE ____________________________________ DATE _______________________