EYECARE REGISTRATION

1 PATIENT INFORMATION

Date _____

Patient _____
Last First M.

Address _____

_____
City State Zip

Sex: ❒ M ❒ F Age _____ Birthdate _____

Home # _____

Patient SS# _____

Driver's License # _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone # _____ Ext.# _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Spouse's Work # _____ Ext.# _____

Best time and place to reach you _____

_____

Whom may we thank for referring you? _____

2 INSURANCE

Name of person responsible for this account _____

Relationship to Patient _____

Name of Primary Care Physician _____

Is this work related? _____

If so, date of injury _____

Primary Insurance Name _____

Address _____

_____

Insured Name _____

Relationship to patient _____

Insured's Date of Birth _____

ID # _____ Group # _____

Is patient covered by additional insurance? ❒Yes ❒No

Secondary Insurance Name _____

Address _____

_____

Insured name _____

Relationship to patient _____

Insured's Date of Birth _____

ID # _____ Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____
Relationship Date

3 EMERGENCY CONTACT

IN CASE OF EMERGENCY, CONTACT

(Specify someone who does not live in your household.)

Name _____

Relationship _____

Home Phone _____

Work Phone _____ Ext.# _____

Patient /Guarantor's Mother's First Name

For Identification Purposes Only _____

4 MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____ for any services furnished me by that doctor. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Signature of Beneficiary Date

REF# 106595-ER 11.20.03 TO REORDER CALL INHEALTH RECORD SYSTEMS 800-477-7374