PATIENT REGISTRATION

DATE _____

PATIENT'S NAME _____ PHONE _____

LOCAL ADDRESS _____ APT # _____

CITY _____ STATE _____ ZIP _____

E-MAIL ADDRESS _____

RESPONSIBLE PARTY _____ SPOUSE'S NAME _____

MARITAL STATUS: SINGLE ( ) MARRIED ( ) DIVORCED ( ) WIDOWED ( )

SEX: M ( ) F ( ) AGE _____ DATE OF BIRTH _____

OCCUPATION: (Parent's, if minor) _____
(Former, if retired)

EMPLOYER _____ WORK PHONE _____

EMPLOYER'S ADDRESS _____

CITY _____ STATE _____ ZIP _____

REFERRED BY _____

SOCIAL SECURITY # _____ MEDICARE # _____

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INSURANCE INFORMATION:

FIRST INSURANCE COMPANY NAME _____

NAME OF SUBSCRIBER _____ SUB ID # _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

RELATIONSHIP TO PATIENT _____

POLICY # _____ GROUP # _____

SECOND INSURANCE COMPANY NAME _____

NAME OF SUBSCRIBER _____ SUB ID # _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

RELATIONSHIP TO PATIENT _____

POLICY # _____ GROUP # _____

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PHYSICIANS RELEASE & ASSIGNMENT

I authorize my insurance company to pay Eye Surgery Associates directly any benefits due or otherwise payable to me.
I further authorize the release of any medical information required by my insurance carrier(s).
A copy of this authorization may be used in lieu of the original.
I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or any related medical claim.
I request payment of medical insurance benefits either to myself or to the party who accepts assignment.
I understand that I am financially responsible for charges not covered by this authorization.

PATIENT'S SIGNATURE _____