



Eye Surgery Associates

Diplomates, American Board of Ophthalmology

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- 2300 N. Commerce Pkwy, Suite 307, Weston, FL 33326 Tel: (954) 217-3155

PATIENT REGISTRATION

DATE _____

First Name:		Last Name:		Phone Numbers:	
Address:		Apt Number:		Home:	
				Work:	
				Cell:	
City:		State:	Zip Code:		Social Security #:
Email Address:			Marital Status:		
			Single () Married () Divorced () Widow ()		
Sex: Male () Female ()		Age:	DOB:		Race/ Ethnicity:
Occupation: (former if retired)		Employer:			
Employer Address:		City:	State:	Zip:	
Referred By: PCP () Optometrist () Friend () Relative () Other: ()		List Full Name and Phone number for Referring Doctor:			

INSURANCE INFORMATION:

Primary Insurance Company Name:		Primary Subscriber Name:	
		DOB: Social Security #:	
Policy (ID)Number:	Group #	Relationship to Patient: Self () Spouse () Parent ()	
Insurance Address:		Insurance Telephone number:	
Secondary Insurance Company Name:		Primary Subscriber Name:	
		DOB: Social Security #:	
Secondary Policy Number:	Group #	Relationship to Patient: Self () Spouse () Parent ()	
Insurance Address:		Insurance Telephone number:	

Physician's Release and Assignment: I authorize the release of Medical and other information necessary to process and receive payment on health insurance claims. I also request payment of benefits be made to my Provider. A copy of this authorization may be used in lieu of the original.

Financial Agreement: I understand that I am financially responsible for any charges incurred for services provided. If I have health insurance coverage and my provider is in network, I understand that I'm financially responsible for all co-payments, deductibles, and co-insurance associated with covered services. If I have out of network benefits and my provider is out of network, I understand that I will be responsible for higher co-insurance, deductibles, and co-payments. If I choose to have non-covered services performed, I will be responsible for the full payment of those charges. Outstanding patient balances over 60 days will incur a charge at the highest rate allowed by law. If my account is sent to collections for lack of payment I agree to pay my provider's fees and expenses incurred in collecting any such amounts, including without limitation, attorney's fees and costs.

I hereby consent to receive marketing materials from Provider from time to time.

Patient's / Guardian Signature _____