

PATIENT REGISTRATION INFORMATION

PERSONAL INFORMATION

Date: ___/___/___

Mr _____ Birthdate: ___/___/___ Male
 Mrs Firstname Mid.Init. Lastname Female
 Ms
 Dr _____ PO Box # _____ Soc. Sec.# _____
Street Address

City State Zip

Phone # () _____

Home
 Message

Work # () _____

_____ e-mail address for appt reminders and recalls

Allow additional e-mail's Y N

SPOUSE [or] PARENT INFORMATION

_____/_____/_____
Firstname Mid.Init. Lastname Birthdate

Street Address Soc.Sec.#

City State Zip () Phone # Home
 Work
 Message

OCCUPATION (Policy Holder, Employer is needed even if retired . If insurance is paid by patient, write 'SELF')

Employer name Job Title

Street Address Phone # Home
 Work
 Message

City State Zip

Patient Spouse Parent

ADDITIONAL PARENT INFORMATION

_____/_____/_____
Firstname Mid.Init. Lastname Birthdate

Street Address Soc.Sec.#

City State Zip () Phone # Home
 Work
 Message

OCCUPATION (Policy Holder, Employer is needed even if retired . If insurance is paid by patient, write 'SELF')

Employer name Job Title

Street Address Phone # Home
 Work
 Message

City State Zip

Patient Spouse Parent

MEDICAL INFORMATION

Doctor name Phone # () _____

Street Address City State Zip

INSURANCE INFORMATION

Vision: _____ Health: _____
Name of vision care insurance company Name of health care insurance company

REFERRAL INFORMATION

Please let us know how you heard about West Branch Eyecare:

Friend Phonebook Dr referral School Already a patient
 Family Newspaper Employer Chamber Other _____

**** OVER ****

MEDICAL ASSIGNMENT & RELEASE AGREEMENT

I request that payment of authorized insurance benefits be made on behalf of **West Branch Eyecare** for services furnished to me by the physician. I authorize any holder of medial information about me to release the Health Care Financing Administration and its agents any information needed to determine these benefits or the payment for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other insurance" is indicated in the item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes 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, non covered services, and non assigned claims. Coinsurance and the deductible are based on the charge of the assigned Medicare carrier. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES NOT COVERED BY MY INSURANCE. THERE WILL BE A \$3.00 PROCESSING FEE EACH BILLING AFTER THE FIRST MONTH AND A \$20.00 FEE IF SENT TO A COLLECTION AGENCY.**

West Branch Eyecare is given permission to send/receive reports to/from other doctors, specialists or family members, to call in prescriptions to your pharmacy for you, and to bill your insurance. Please specify any persons you **Don't** want information released to

By signing I also acknowledge that I received a copy of WEST BRANCH EYECARE'S Notice of privacy practices

(signature) _____ Dated ____/____/____