

PATIENT REGISTRATION

DATE _____

PATIENT NAME _____ SS # _____

IF MINOR, PARENT'S NAME _____ WORK # _____

DOB _____ AGE _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME # _____ CELL # _____ BPR# _____

EMAIL ADDRESS _____

SEX: () FEMALE () MALE MARITAL STATUS: () S () M () D () W

EMPLOYMENT INFORMATION
(If patient is a minor, parent's info)

EMPLOYED BY _____ WORK # _____

REFERRED BY _____ FAMILY PHYSICIAN _____

RESPONSIBLE PARTY OR SPOUSE _____

PRIMARY INSURANCE INFORMATION

MEDICARE # _____ MEDICAID # _____

NAME OF INSURANCE _____

NAME OF SUBSCRIBER _____ DOB _____

POLICY # _____ GROUP# & NAME _____

SECONDARY INSURANCE

NAME OF INSURANCE _____

POLICY # _____ GROUP# & NAME _____

PHYSICIAN'S RELEASE & ASSIGNMENT

I request that payment of authorized Medicare/Insurance benefits be made either to me or on my behalf to Miami Lakes Eye Care Center for any services furnished me by that physician or supplier. I authorize any holder of medical information to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to 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 coverage is indicated on Item 9 of the HCFA-1500 claim form or elsewhere on other approved 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, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier. It is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT'S SIGNATURE _____

(If minor, parent/guardian signature)