Ophthalmic Associates

Patient Registration Form

Last Name

First Name

Middle Name

Date of Birth

Sex

Home Phone

Street Address

City

State

ZIP Code

Occupation

Employer

Employer Address

Business Phone

Spouse Name and Phone Number

Nearest Friend/Relative and Phone Number

Primary Insurance

Policy Holder

Policy Number

Secondary Insurance

Policy Holder

Policy Number

Policy Holder’s Date of Birth

Primary Care Provider

Who Referred You to Our Office?

If you use a computer and would like to receive updates or notices by email, please write your email below:

Email address

Ophthalmic Associates

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PLEASE COMPLETE THIS SECTION ONLY IF SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE FOR PAYMENT

Responsible Party Name

Street Address

City

State

ZIP Code

PLEASE COMPLETE THIS SECTION ONLY IF THIS IS A WORKERS' COMPENSATION CLAIM

Employer's Name

Employer's Address

Employer's Phone

Date of Injury

Claim Number (if known)

I have completed this form fully and completely, and certify that I am the patient or duly authorized agent of the patient authorized to furnish the information requested. I understand that even though I have some type of insurance coverage, I am responsible for payment of services rendered or products ordered:

Signature

Date

I authorize any holder of medical or other information about me to release any such information, to Medicare or any other insurance company, its intermediatries or carriers, required to process this or a related claim. I permit a copy of this authorization to be used in place of the original and request any payment of medical insurance benefits be made directly to OPHTHALMIC ASSOCIATES

Signature

Date

I acknowledge having received a copy of the practice's Notice of Privacy Practices

Signature

Date