Ophthalmic Associates Patient Registration Form

____
Last Name

____
First Name, Middle Initial

____
Gender Race/Ethnic Background

____
Street Address

____
City/State/Zip Code

____
Occupation/(Former if Retired)

____
Employer

____
Home Phone Cell Phone

____
Date of Birth

____
Social Security Number

____
Spouse's Name and Phone Number

____
Nearest Friend/Relative & Phone #

____
Who Referred You to our Office?

____
Primary Care Physician

____
E-Mail Address

****

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

____
Responsible Party Name

____
Relationship to Patient

____
Street Address

____
City, State, Zip Code

____
Date of Birth

____
Social Security Number

Is this a Workers Compensation Claim?

YES _______ NO _______

OVER →

Ophthalmic Associates Patient Registration Form

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 ultimately responsible for payment for services rendered or products ordered or supplied. I understand that if payment, in full, for services rendered or products ordered or supplied is not received within 90 days, the account will be transferred to an outside collection agency. I, understand that at that time I will be responsible to pay the collection fees which range from 35% to 50% of the outstanding balance.

____

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 intermediaries or carriers, required to process claims on my behalf. 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 or have waived my right to receive same.

____

Signature Date

Would you like to have any of your Protected Health Information, including test results, billing questions, appointment details, etc. discussed with anyone besides yourself as the patient?

YES _______ NO _______