

Overlake EyeCare, PS

Patient Registration Form

P A T I E N T	LAST NAME	FIRST NAME	M. I.	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
	ADDRESS	CITY	STATE/PROV	POSTAL CODE	COUNTRY (if not USA)
	HOME PHONE ()	WORK PHONE / EXT ()	BIRTHDATE MM/DD/YYYY	SALUTE <input type="checkbox"/> MR. <input type="checkbox"/> MRS. <input type="checkbox"/> MS. <input type="checkbox"/> MISS <input type="checkbox"/> DR.	
	SOCIAL SECURITY NUMBER	EMPLOYER	POSITION		

B I L L I N G	<input type="checkbox"/> SAME AS ABOVE	LAST NAME	FIRST NAME	SALUTE <input type="checkbox"/> MR. <input type="checkbox"/> MRS. <input type="checkbox"/> MS. <input type="checkbox"/> MISS <input type="checkbox"/> DR.		
	ADDRESS	CITY	STATE/PROV	POSTAL CODE	HOME PHONE ()	WORK PHONE / EXT ()

E M E R G E N C Y	LAST NAME	FIRST NAME	SALUTE <input type="checkbox"/> MR. <input type="checkbox"/> MRS. <input type="checkbox"/> MS. <input type="checkbox"/> MISS <input type="checkbox"/> DR.			
	ADDRESS	CITY	STATE/PROV	POSTAL CODE	HOME PHONE ()	WORK PHONE / EXT ()

R E F E R R A L	HOW DID YOU SELECT OUR OFFICE?
	<input type="checkbox"/> DOCTOR'S REFERRAL * <input type="checkbox"/> FAMILY/FRIEND * <input type="checkbox"/> INSURANCE CO. <input type="checkbox"/> NEWSPAPER <input type="checkbox"/> RADIO <input type="checkbox"/> T.V. <input type="checkbox"/> YELLOW PAGES
	* NAME OF THE PERSON WHO REFERRED YOU

P A Y M E N T	HOW WILL YOU BE PAYING?
	<input type="checkbox"/> CASH <input type="checkbox"/> CHECK (\$25 charge for all returned checks) <input type="checkbox"/> INSURANCE
	<input type="checkbox"/> AMEX <input type="checkbox"/> DISCOVER <input type="checkbox"/> MASTERCARD <input type="checkbox"/> VISA

I N S U R A N C E	PRIMARY VISION INSURANCE COMPANY	SECONDARY VISION INSURANCE COMPANY
	PRIMARY MEDICAL INSURANCE COMPANY	SECONDARY MEDICAL INSURANCE COMPANY
	NAME OF PRIMARY CARE PHYSICIAN	LOCATION OF PRIMARY CARE PHYSICIAN

S I G N A T U R E	OFFICE FINANCIAL POLICY, PRIVACY PRACTICES ACKNOWLEDGEMENT AND INSURANCE LIFETIME AUTHORIZATION		
	When we bill your insurance company, you are still directly responsible for any fees that they do not pay including co-payments, deductibles and non-covered services. If you are covered by managed care insurance that requires prior authorization for our services you are responsible for obtaining the authorization before we render services. We will apply a \$3.00 statement charge each month to all accounts that are over 60 days past due. You acknowledge that you have reviewed or have been given a copy our office's notice of privacy practices as required by HIPAA. You authorize Overlake EyeCare, PS to utilize your existing eye care records. You also request payment of government or private insurance benefits to Overlake EyeCare, PS when we accept assignment for services and materials provided to you.		
	PATIENT/RESPONSIBLE PARTY'S SIGNATURE	DATE MM/DD/YYYY	RELATIONSHIP TO INSURED <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER